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Table of Contents

A Greeting

ON behalf of the Federal Council of the British Medical Association, I have great pleasure in welcoming to Australia the members of the Council of the World Medical Association and their wives. Australia has been a member nation of the World Medical Association since 1948, and my Council has always appreciated the importance of such a body, organized by the medical profession itself in different parts of the world. At a time when differences and tensions between various nations are so prevalent, it is a source of pride to us that the medical profession has played a prominent part in fostering a spirit of fellowship and goodwill amongst its members on a world-wide basis irrespective of race or creed. We are gratified that our own Australian representative has been elected Chairman of the Council of the World Medical Association, and my Council will join with him in endeavouring to ensure that this, their first meeting to be held in Australia, will be a memorable one, and enjoyed by all who take part in it.

H. CECIL COLVILLE,
President,
Federal Council of the British Medical Association in Australia.

Health Care in Australia

THE theme of medical care in Australia is essentially that of private practice, which functions on the fee for service principle. There are more than 11,000 medical practitioners in the seven States and Capital Territory, representing a ratio of 1:900 per head of population (10,000,000). Of these practitioners approximately 60% are general practitioners, 23% are specialists and 17% salaried medical officers.

The highest concentration of medical practitioners, and particularly of the specialists, occurs in the six State capital cities, where half the total population of Australia is to be found. In the last decade there has been an increasing tendency for specialist practices to be established at the more important provincial cities, particularly in group practices.

In the country areas, with their great open spaces and sparse population, the challenge of coping with a multitude of medical problems has bred a very resourceful and efficient general practitioner. The five medical schools, which are incorporated in the universities at Sydney, Melbourne, Brisbane, Adelaide and Perth, have ensured that a good working knowledge in all the major disciplines is given to the undergraduate, whilst post-graduate revision and training are encouraged through a variety of organizations.

Specialist training is also readily available, and there are established colleges—for example, The Royal Australasian College of Physicians and the Royal Australasian College of Surgeons—which grant higher degrees in the various specialties. Nevertheless, many graduates seek wider experience, frequently in the United Kingdom and the United States of America, and take the overseas higher degrees in addition to the Australian.

The National Health Service.

The Federation of the Australian States forming the Commonwealth took place in 1901, the Constitution, a written one, being an adaptation of the principles of British and colonial government to the Federal system. Under the Constitution the Commonwealth's interest in health measures was restricted to the control of quarantine services throughout Australia. However, for some years prior to the second World War, various Commonwealth Governments carried out investigations to gain factual information on medical practice in Australia with a view to introducing a national health service.

A *National Insurance Act*, which provided *inter alia* for the furnishing of medical services to employed persons, was passed in 1938 by the then Liberal Government. However, because of unacceptable conditions the medical profession refused to cooperate, and the Act became a dead letter.

In 1944 the then Labour Government legislated to introduce a *Pharmaceutical Benefits Act*, a basic provision of which was that medicines, if the patient was to receive them free, must be prescribed from a Government formulary of drugs. Parliament passed the legislation in 1945, believing that authority to do so was contained in the financial and incidental powers of the Constitution.

To understand the constitutional obstacles to any such scheme, it is necessary to recall that the Federal Government cannot legislate in a manner inconsistent with any definite head of power written into the Constitution itself.

Strong exception was taken by the profession to the provisions of the Act, and the measure was nullified when, in 1945, the Medical Society of Victoria, applying through the State Government to the High Court, obtained the declaration that the Act was *ultra vires* the Constitution and so was invalid.

After this defeat, the Federal Government (Labour Party) at the elections in 1946 asked the people, by referendum, for an amendment to the Constitution, granting an extension of powers. The referendum, which was approved with the concurrent return to power of the Labour Party, authorized the Commonwealth Parliament to make laws with respect to "the provision of maternity allowances, widows' pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students, and family allowances". The words "but not so as to authorize any form of civil conscription', which were to be of vital importance to the medical profession in its fight for freedom, were inserted on the proposal of the then Leader of the Opposition (now Prime Minister), the Right Honourable R. G. Menzies, following a suggestion by the President of the Federal Council of the British Medical Association in Australia at that time, Sir Henry Newland.

Conferences, in an attempt to achieve a satisfactory agreement in regard to a national health scheme, were then held between the Government and the Federal Council of the British Medical Association, representing the profession; but when the new *Pharmaceutical Benefits Act* was introduced in 1948, it still contained penal and restrictive clauses (for example, a set formulary) completely unacceptable to the profession. Approximately 98% of the doctors, acting on the advice of the Association, refused to take delivery of the Government's prescription forms and to use the formulary.

In desperation, the Government, early in 1949, introduced into the Act an amendment prohibiting doctors from prescribing any medicament, compounded or not compounded, contained in the Government formulary, except upon the prescription forms supplied by the Government. Immediately it was realized that doctors must either cooperate in the scheme or lose the right to prescribe lawfully a number of the medicaments used in their practices—for example, sulphonamides, adrenaline, antibiotics, etc.

The Federal Council of the British Medical Association in Australia, backed by the profession almost to a man, took the legislation to the High Court, which, in October, 1949, upheld the profession's appeal that the Act was tantamount to civil conscription and accordingly *ultra vires* the Federal Constitution. The Labour Government, which in its term of office had contemplated nationalizing the banks, shipping, airlines, insurance, the medical profession and even control of the Press, faced a hostile public at the triennial elections two months later.

A coalition Liberal-Country Party Government was returned to power in December, 1949, and under its present leader, Robert Gordon Menzies, has continued to occupy the Government benches. The Ministry of Health was delegated to the care of an eminent member of the medical profession, a country general practitioner, Sir Earle Page, P.C., G.C.M.G., C.H., M.P., who in his thirty-nine years in Parliament has assumed many offices, including that of Prime Minister.

Sir Earle Page, fully appreciative of the principles and views of the profession, proceeded to introduce, in stages, a new health service, which has met with general approval. Dr. Donald A. Cameron, O.B.E., another country general practitioner, who succeeded Sir Earle Page as Minister for Health in 1955, has been instrumental in amending the *National Health Act* from time to time to increase the benefits available.

The National Health Service, which now involves an annual expenditure of £50,000,000, incorporates the following measures.

Pharmaceutical Benefits (introduced 1950).

All life-saving and most disease-preventing pharmaceutical drugs are listed in the Schedule of Pharmaceutical Benefits, and are available free of charge to every citizen in Australia on the prescription of a legally qualified medical practitioner. An expert committee, on which the profession is adequately represented, and whose chairman is the present Chairman of the Council of the World Medical Association, constantly reviews the drugs which are available, and recommends to the Minister for Health those that should be added to or deleted from the Schedule, which at the moment contains 241 items. Medicines containing pharmaceutical products not on the Schedule must be paid for by the patient.

There are no penalties for doctors for breaches of the regulations, the only offences for which a doctor can be charged being either a crime or a misdemeanour—for example, fraud. Form of prescription (size and shape), quantities prescribable and number of repeats are defined in the regulations. This section of the *National Health Act* has proved the most expensive to the Government and this year alone will cost the Treasury £14,550,000.

Medical Benefits (introduced 1953).

There was in existence in 1953 a number of voluntary pre-paid health insurance funds, including some which had had many years of practical experience in this field. These funds, the largest of which, the Medical Benefits Fund of Australia, was established by the New South Wales Branch of the British Medical Association in 1947, provide "family insurance", the contributor's subscription also entitling his wife and his children aged under 16 years to receive full benefits. A reduced subscription is paid by single persons without dependants.

The Commonwealth Government, in its wisdom, elected to subsidize the benefits paid by these funds, which collect a flat rate of contribution from their members and reimburse them, according to an itemized schedule of benefits, for medical expenses incurred.

The Commonwealth Government adopted a schedule of benefits which included almost every service the medical profession could render, and stipulated that any medical benefits fund seeking registration with the Commonwealth Scheme must at least match, from its own funds, the benefits payable by the Commonwealth.

Receipted accounts are received by the various recognized funds from the contributors, who are then paid the combined Commonwealth and fund benefit by the medical fund, provided that the total benefit does not exceed 90% of the doctor's fee for any item. The fund, in turn, is reimbursed by the Commonwealth Government for that moiety which is the Government's responsibility. Thus no third party intervenes between the patient and doctor. The fund organizations, however, receive no Commonwealth compensations for their administrative costs.

There is an initial "waiting period" of two months before benefits are available to new contributors, except in the cases of accidents.

There is complete freedom of choice of doctor by patient and of patient by doctor, and there is no State interference in where and how a doctor practises, provided that he observes the usual ethical and legal requirements.

The benefits paid do not distinguish between the services rendered by general practitioners and specialists except in the case of specialist consultations, when a greater benefit is paid if the patient is referred by another medical practitioner.

Contributors suffering from preexisting ailments at the time of joining the fund were previously excluded for a period of two years from receiving the fund benefit for treatment of such disabilities, although the Commonwealth's benefit was payable immediately. As a result of an amendment to the *National Health Act*, since January, 1959, the contributor now receives a fund benefit in addition to the Commonwealth benefit. The contributor's subscription is paid into a special fund, guaranteed by the Commonwealth, and is lost by the particular medical benefit fund organization.

In Table I are listed examples of benefits paid by the Medical Benefits Fund of Australia Limited, which grants a fund benefit of 166⅔% of the Commonwealth benefit.

One criticism of the present Schedule is that the Government has failed to increase the benefits to match the increased cost of living since 1953, which has been responsible for an upward trend in medical fees. Originally the Government envisaged that total benefits would cover close to 90% of the average fees charged by general practitioners and some specialists. However, the discrepancy is such now that the patient, in addition to his annual subscription to the fund, is also obliged to meet approximately 37% of the practitioner's fees, the fund meeting 34% and the Commonwealth Government 29%. Another deficiency in the medical benefits scheme is the inability of the patient to insure himself against major surgical expenses.

TABLE I.

Type of Service.	Fund Benefit.	Commonwealth Benefit.	Total.
	£ s. d.	£ s. d.	£ s. d.
General practitioner services[1]:			
Consultations, per attendance	0 7 6	0 6 0	0 13 0
Visits, per attendance ..	0 9 0	0 6 0	0 15 0
Specialist's services[2]:			
First visit (when referred by another practitioner) ..	1 13 0	1 0 0	2 13 0
Subsequent visits	0 16 6	0 10 0	1 6 6
If not referred by another practitioner	0 15 0	0 6 0	1 1 0
Midwifery[3]:			
Confinement, including antenatal care and post-natal care for nine days	6 5 0	3 15 0	10 0 0
Cæsarean section	12 10 0	7 10 0	20 0 0
Operations[4]:			
Removal of tonsils and adenoids—			
Adults	5 0 0	3 0 0	8 0 0
Children	3 2 6	1 17 6	5 0 0
Cholecystectomy	18 15 0	11 5 0	30 0 0
Appendicectomy	9 7 6	5 12 6	15 0 0

[1] Total fund benefits of £30 available each year per person. No Commonwealth limit.

[2] Total fund benefits of £30 available each year per person. No Commonwealth limit. Commonwealth benefit is not available for eye refraction tests.

[3] Additional benefits are provided for special services.

[4] Benefits for a full range of operations are provided. Surgery benefit includes normal post-operative care. There is no annual benefit limit for surgery or anæsthetics.

At June, 1958, there were 81 registered organizations in Australia having a total membership of 2,422,800 with a coverage of 6,148,000, or 63% of the population. However, as it is probable that about 20% of the total population are covered by pensioner schemes (7%) or medical services for members and ex-members of the armed forces (3%), or those who are unwilling or unable to join an approved fund (10%), the figures shown above virtually represent a coverage of at least 75% of the insurable population.

The cost of the medical benefits scheme to the Commonwealth Government this year will be £8,300,000.

Hospital Benefits (introduced 1952).

There are in Australia some 850 private and 750 public hospitals. Most of the larger private hospitals are maintained by the various religious orders, but usually they receive some government assistance. During the last decade the increasing cost of maintaining private hospitals has forced many of the smaller establishments to close down, and it is more than likely that, in future, most new hospitals will be erected by the governments.

The hospital benefits of the National Health Service are also managed according to contributory schemes, with the exception that a Government benefit is paid in every case, whether or not the patient contributes to a hospital fund. Although the provision and control of public hospitals are vested in State Governments, the Commonwealth Government pays to the State a sum of 8s. for each day a patient occupies a bed in any hospital registered by the Government to receive such assistance.

If the patient voluntarily contributes to an approved hospital benefit fund, the Commonwealth pays an additional sum of 4s. per day towards the hospital charges.

Contributors may subscribe to hospital funds at varying rates to receive different benefits, and should they be insured to receive 16s. per day fund benefit, then the Commonwealth grants an additional sum of 8s. per day, making a total Commonwealth benefit of 20s.[1] per day and a combined fund and Commonwealth benefit of 36s. per day—£12 12s. per week. The highest table available in any one fund returns to the contributor £23 16s. per week.

Patients suffering from disabilities which were in evidence at the time of their joining the fund, or which subsequently developed and became sufficiently chronic to warrant such a classification, were precluded by the rules of the hospital funds from receiving fund benefit for those particular disabilities. However, since January this year the Commonwealth Government has assumed responsibility to meet up to £12 12s. per week of the expenses so incurred by fund contributors when they are admitted to hospital for treatment of these excluding disabilities. As in the case of medical benefits, the subscriptions of hospital benefit contributors suffering from the excluded disabilities are deposited in a special fund guaranteed by the Commonwealth Government, from which the particular hospital expenses are paid.

Invalid, old-age and widow pensioners are exempted from all hospital charges, and persons in indigent circumstances also receive sympathetic consideration.

Pensioner Medical Service (introduced 1951).

Formerly patients in receipt of old age, invalid or widows' pensions were largely dependent on the generosity of the medical practitioners to render services gratis or at concessional rates, or alternatively were obliged to seek treatment at the out-patient departments of public hospitals.

In 1951 the Commonwealth Government introduced the Pensioner Medical Service, by which general practitioners provide, at the Commonwealth's expense, family doctor service, including such services of a minor or special character as are usually rendered by a general medical practitioner in his surgery or in the patient's home. The service does not extend to specialist treatment. The scheme is based on the fee-for-service method of payment, the patient at each consultation signing a voucher authorizing the Government to pay the doctor on his or her behalf. Thus the doctor-patient relationship is again maintained without the intervention of a third party.

The fee paid by the Government for medical attendance on a pensioner is about 40% less than that normally charged by a doctor to his private patients. The profession has always emphasized that it is thus providing a service at a concessional rate. The Government justifies the lower rate on the grounds that the doctor is assured of payment, whereas in the past it was the custom to treat pensioners either free or for a very small fee. Participating practitioners receive 11s. per consultation at the surgery and 13s. for each domiciliary visit. There is a special mileage allowance of 4s. per mile payable by the Commonwealth where the practitioner has to travel, mainly beyond two miles, and the pensioner may be asked to pay an additional 1s. per mile, but not more than a total of 10s.

The practitioner may, but usually does not, charge the patient a fee of 5s. for a consultation outside regular consulting hours.

This Scheme has been immensely popular with the beneficiaries, who number 675,000, and has no doubt gone far towards improving their general health and well-being. The cost this year is anticipated to be £3,750,000.

There is in each State a Medical Services Committee of Inquiry appointed under the *National Health Act*. The members are selected from nominees of the British Medical Association in Australia, and it is their function to investigate apparent abuses by doctors of the Pensioner Medical Service. The Committees make their reports to the Commonwealth Minister for Health, who has powers to suspend medical practitioners, reprimand them, or disallow their claims on the Commonwealth for remuneration of the service to pensioners.

Pharmaceutical Benefits to Pensioners.

As was previously mentioned, the life-saving and other selected drugs are available free as general benefits to every citizen, but the Government has also introduced a more comprehensive scheme for the pensioners' requirements.

The Schedule for this scheme is based on the list of drugs appearing in the British Pharmacopœia, and there are very few pharmaceutical requirements for pensioners that are not available completely free through this scheme. The cost of the service this financial year will be £2,555,000.

Tuberculosis Allowances.

Since June, 1949, tuberculosis allowances are paid to sufferers from tuberculosis and their dependants, with the object of encouraging sufferers to refrain from working and undergo treatment, minimizing the spread of tuberculosis and promoting the better treatment of the disease. The rates of allowance are: £9 10s. 6d. a week for a married sufferer and a dependent wife; £5 12s. 6d. a week for a sufferer without dependants (reducible to £3 10s. when maintained free of charge in an institution); and 10s. a week for each dependent child under the age of 16 years—which is additional to child endowment. There is a means test, generous to the sufferer, which has regard only to income and not to property.

As the Commonwealth also makes grants to the States for the erection and maintenance of tuberculosis hospitals and reimburses the States for their expenditure on chest surveys, the total cost to the Commonwealth Government for its fight against the disease exceeds £8,000,000 *per annum*.

The success of the activities of the Commonwealth and State Governments in their fight against the disease can be gauged by the fact that the death rate from tuberculosis has been reduced from 23·3 per 100,000 of population in 1949, to 6 in 1959, and that the average number of persons needing to draw the allowance declined from the peak of 6712 in April, 1952, to 2172 in March, 1958.

Free Milk Scheme for Children.

Since 1950, the Commonwealth Government has provided one-third of a pint of milk per day free to every school child up to 12 years of age (£2,750,000 *per annum*).

Other Commonwealth Government Commitments.

Other commitments of the Commonwealth Government in the province of health are the following:

1. Grants to State Governments for capital expenditure on mental institutions (£1,250,000 *per annum*).

2. Subsidizing the Royal Flying Doctor Service (£237,000 *per annum*). Australia is a vast country, three-quarters of which is open plains and a large part desert, on which there is a sparsely settled population, isolated in many instances from the benefits of medical care except for that unique organization, the Royal Flying Doctor Service of Australia. This outstanding feature of the medical services of Australia came into being as a result of the interest and enthusiasm of the late Reverend John Flynn, C.B.E., of the Australian Inland Mission, a Presbyterian Church organization. Despite great difficulties, Flynn, with the support of interested lay persons and members of the medical profession, established the first Flying Doctor base at Cloncurry. The services of the Australian Flying Doctor are free, and are available instantly in time of need to all, with no distinction of colour, caste or creed, and with no calculation of cost or fee. The movement is maintained by voluntary contribution and subscriptions, with Government subsidy. The Flying Doctor bases are located at Broken Hill (N.S.W.), Charleville and Charters Towers (Q.), Port Augusta (S.A.), Alice Springs (N.T.), Wyndham, Port

[1] £1 (20s.) Australian = $2·2352.

Hedland, Kalgoorlie, Meekatharra, Carnarvon and Derby. These bases are under the control of the respective State sections, each holding itself responsible for provision of doctor, an aeroplane and a remarkable radio network that operates in each area for all necessities of urgent communication. The work of the service is coordinated by a Federal Council consisting of two representatives of each State section. The Commonwealth itself has a Flying Doctor Service at Darwin (N.T.).

3. Contributing to the cost of maintaining the Blood Transfusion Service of the Australian Red Cross Society.

4. Providing a medical and hospital service in the Northern Territory of Australia, and maintaining a hospital at Canberra in the Australian Capital Territory.

5. Fostering medical research in Australia by the establishment of such organizations as the National Health and Medical Research Council, the Commonwealth Scientific and Industrial Research Organization, and the John Curtin School of Medical Research.

6. Production and free distribution to the States of Salk vaccine.

7. Paying maternity allowances to mothers, to provide financial assistance towards the expenses associated with the birth of children. These are additional to the benefits provided under the Commonwealth hospital benefits scheme. They are not subject to any means test. The allowance is £17 where there are no other children.

8. Providing child endowment to persons with family responsibilities. It may be claimed by any person who is resident in Australia and has the custody, care and control of one or more children under the age of 16 years. There is no means test. A sum of 5s. a week is paid for the first child and 10s. a week for each other child.

9. Repatriation benefits. Pensions are paid to ex-servicemen and their dependants for disabilities which arose out of war service. Free medical treatment, drugs and hospital treatment are available through the Government for treatment of these disabilities. Most general practitioners have been appointed by the Repatriation Department as local medical officers, and are authorized to carry out treatment for ex-servicemen at the department's expense, on a fee-for-service basis. Dependants of deceased ex-servicemen are provided with a free medical and pharmaceutical service by the department, again through the agencies of the local medical officers.

10. Quarantine services. Owing to its isolation, Australia has always been in a favourable position to safeguard itself against the introduction of diseases from other countries. The problem has, of course, required increased vigilance with the advent of air travel.

State Public Health Legislation and Administration.

In the Australian States, the Departments of Health are under the control of State Ministers for Health and are administered by State Directors-General of Health. The departments embrace activities of the various health divisions which, in the larger States, are frequently under the supervision of a director. The main activities of the Departments of Health are as follows.

Public Health.

Supervision of health matters in the sphere of local government is controlled by the department, together with environmental sanitation, supervision of abattoirs and crematoria, and registration of factories and bake-houses, hairdressers, and places of entertainment. Under the pure foods Acts, the display and sale of food to the public is controlled. The manufacture and sale of drugs, particularly poisonous or dangerous drugs, are supervised.

Control is exercised over the prevention and treatment of venereal disease, notification of infectious diseases, and immunization campaigns. For some years free immunization against diphtheria, and since 1956 against poliomyelitis, has been offered by most local authorities. Recent surveys show that approximately 90% of school children have been immunized against diphtheria and poliomyelitis, with a marked reduction in the incidence and death rates of the diseases.

Tuberculosis.

As was previously mentioned, in cooperation with the Commonwealth Government the States carry out an unceasing campaign against tuberculosis. The branch or division is usually under a medical practitioner who exercises control over State sanatoria, tuberculosis clinics, tuberculosis bureaux and mass X-ray surveys. In order to exercise better control over the spread of tuberculosis, several of the States have legislated to empower the chief health officer to require any individual or any group of persons to undergo radiological examination of the chest.

Industrial Medicine.

The division of industrial medicine exercises supervision over the health of workers in both primary and secondary industries. In each State, employers are required by law to cover workers under a comprehensive workers' compensation insurance. This insurance covers the worker for medical expenses and loss of wages through any disability arising out of or in his employment or whilst travelling to and from work, and provides for compensation for any permanent disability arising out of such injury.

Maternal and Child Welfare.

This branch is concerned with pre-natal hygiene, infant health, pre-school child and school medical and dental services. An extensive State-wide free correspondence scheme for women during their pregnancy and early motherhood supplies them with all the latest advice and information.

Medical Inspection of School Children.

Medical inspection of school children is carried out in all the States and the Australian Capital Territory. Medical staffs have been organized, and in some States travelling clinics have been established to deal with dental and ocular defects.

The primary object of the service is the medical examination of children, to discover any departure from normal in the health of the child, either physical or mental, and to notify the parent or guardian in order that the child may be further investigated to determine the need for treatment. In many cases it is not possible to make a diagnosis of the conditions found at the time of the examination. This is due partly to the fact that only a limited time can be devoted to each individual examination, and also to lack of facilities within the service for further investigation. Treatment is accepted as the responsibility of the practising medical profession.

Mental Hygiene.

The Department is responsible for the care, treatment and accommodation of mental patients throughout the State.

Scientific and Laboratory Services.

Laboratories are maintained to ensure the purity of a wide range of foodstuffs and materials, and also offer a service in clinical pathology to country hospitals and private medical practitioners.

Registration of Medical, Dental, Nursing and Allied Services.

Through the various medical practitioners' Acts, nurses Acts, opticians' registration Acts, etc., control is exercised over the conditions and qualifications necessary for registration of the medical, dental, nursing and allied professions in the various States. The conditions of registration differ in the various States, and registration in one State does not necessarily entitle the applicant to registration in another State.

Hospitals.

As was previously mentioned, State supervision is exercised over the conditions under which all public and private hospitals operate.

All public hospitals are controlled by a branch of the Department of Health, or by a special board or commission. These public hospitals are staffed, for the most part, by visiting medical officers appointed in an honorary capacity. In Queensland, however, visiting medical officers are paid a salary. The honorary staffs are precluded by law from receiving payment for services rendered to patients in public wards, but fees are charged to patients in private and intermediate wards, and an ever-increasing number of the population is making use of these "pay-beds". Again, no charge is made for medical attendances rendered to out-patients, although the hospitals usually make a charge for the use of the hospital facilities.

With the exception of the State of Queensland, there is no free hospital accommodation provided by the Government. Patients in all wards are expected to pay; but where genuine hardship is proved, full payment for public ward accommodation is not pressed. In Queensland, in-patients who are eligible for treatment under the *Workers' Compensation Act* or are eligible for third party insurance are charged a nominal fee.

In the States other than Queensland and Tasmania, where any patient may elect to enter a public ward, a means test is applied, which is liberal in its scope, and virtually permits most patients in the lower income brackets to enter public wards and to receive free in-patient treatment if they so desire. Charges for public ward accommodation vary from State to State, but in New South Wales the fee is 12 guineas per week, although the average cost of maintaining a bed in a public hospital is in the vicinity of £30 a week.

Most public hospitals also provide a limited amount of private (25 guineas per week) and intermediate (18 guineas per week) accommodation.

In Victoria, a unique feature of the hospital service in isolated areas is the Bush Nursing Hospitals, which are owned and controlled locally by committees under the ægis of the Victorian Bush Nursing Association. Legally they are private hospitals in which any member of the community may receive treatment, but persons paying an annual subscription are entitled to substantial reduction in fees.

In those areas of Tasmania where the population is scattered, municipalities may raise a levy which is paid to a salaried "district medical officer", whilst the Department of Health makes up the difference between the district medical officer's total remuneration and the "retaining fee" raised by the municipality. The doctor may also act as superintendent of the local hospital if one is established. The general practice service so provided is free to all residents from 9 a.m. to 6 p.m., and there is a prescribed fee for services rendered outside these hours.

While the general pattern of health services in Western Australia is comparable with that of the other Australian States, the vast area and relatively sparse population have necessitated the provision of certain special services which are not common to all the other States. The under-populated north-west is served by salaried medical officers of the Department of Health, and they participate in the Royal Flying Doctor Service. The relatively high proportion of aborigines in the State necessitates special services for the treatment and control of diseases such as leprosy, yaws and trachoma. The long distances between settlements generally throughout the State have led to the increasing use of mobile units concerned with infant health, dental treatment and immunization, while a correspondence service is maintained for outback mothers.

The Queensland Government hospital system consists of three sections. (*a*) Two large metropolitan hospitals, staffed by a part-time classified visiting staff, with a large number of full-time medical officers, often of considerable seniority, and especially in the casualty department and the departments of diagnostic radiology, pathology, radiotherapy, anæsthetics and traumatic surgery. In general, the visiting staff controls the treatment of patients. (*b*) A series of base hospitals, in large country towns, with in-patient and out-patient departments. Here the medical superintendent has both the theoretical, and in practice often the actual, control of treatment, though as they become available in the community registered specialists are being attached to them on a part-time basis. (*c*) A large number of small public hospitals, staffed by a full-time or part-time medical superintendent, and sometimes a small number of junior resident doctors. In most cases the private practitioners where hospitals are situated have only a limited access to hospital facilities, and they do not take part in the care of public ward patients. Large numbers of intermediate beds are being made available within the public hospitals, where patients are cared for by their private practitioners on a fee-for-service basis.

Organization of the Medical Profession.

Members of the medical profession first established practices in this country one hundred and seventy years ago. By diligently serving the population and by maintaining a high standard of conduct, they have earned the respect of their fellow citizens and in times of political crises have been fortunate in having their sympathetic support.

The medical profession in Australia has, since 1880, been organized as part of the British Medical Association, and more than 90% of practitioners are members of the six State Branches of the British Medical Association in Australia, each Branch having practically complete autonomy. The membership of each of the six Branches is as follows: New South Wales, 4127; Victoria, 2947; South Australia, 924; Queensland, 1300; Western Australia, 705; Tasmania, 260.

The Federal Council of the British Medical Association in Australia is composed of 15 members elected by the Branches, and generally speaking, acts for and on behalf of the Branches in matters affecting the profession in Australia as a whole, the Branches dealing with State matters. The Association is non-political, but cannot escape some contact with politics. Its attitude is quite simple; if a political party advocates a form of medical service which the profession approves, it supports that party's policy; if any political party advocates a medical service which the profession considers is against the interests of the people and the profession, then the policy is opposed, and there its excursion into politics begins and ends.

By virtue of his membership of the British Medical Association in Australia, a doctor receives two weekly medical journals, the *British Medical Journal* and THE MEDICAL JOURNAL OF AUSTRALIA.

Recent surveys have shown that the medical practitioners as a group receive a more favourable income than any other profession in Australia, and it is also true that they enjoy good social status in the community.

The British Medical Association in Australia

THE FEDERAL COUNCIL.

A PROPOSAL for a consultative body, on matters of common interest to the State Branches, was considered in 1911, at the instance of the South Australian Branch, during the meeting in Sydney of the Australasian Medical Congress.

Delegates from all Branches met, and drafted a constitution for a body to be called "The Federal Committee of the Branches of the British Medical Association in Australia". With slight modifications, this Constitution was adopted by the Branches. It provided, in general, that the Committee should be the medium for communicating with and negotiating with the British Medical Association, on behalf of the Branches in Australia; that it should represent the members in Australia for the purpose of communicating with the Commonwealth Government; and that it should deal with any matter of medico-political or scientific importance affecting organization of the profession in Australia.

Although at that time the Association's constitution did not provide for formation of such a committee, the Federal Committee received official recognition by the British Medical Association in London, in 1914. It did valuable work, especially in connexion with the profession's relation to departments of the Commonwealth Government, and in securing uniformity of policy on matters of importance affecting the profession generally.

In 1922, provision was made in the constitution of the British Medical Association for the formation of federal

FIGURE I.

The Federal Committee of the British Medical Association in Australasia, second session, Sydney, January 7, 8 and 9, 1913. From left to right: Dr. W. T. Hayward, South Australia (chairman), Dr. F. A. Pockley, New South Wales, Dr. G. H. Abbott, New South Wales (honorary secretary), Dr. R. H. Todd (assessor), Mr. A. W. Green, Dr. W. N. Robertson, Queensland, Dr. F. H. Barrington (acting for New Zealand), Dr. W. W. R. Love, Queensland, Dr. F. S. Hone, South Australia, Dr. R. H. Fetherston, Victoria, Dr. S. Gillies (acting for New Zealand), Mr. G. A. Syme, Victoria.

councils, representative of Branches in any area outside Great Britain. Such Councils could be corporate or unincorporate. It was considered that benefit would accrue if a federal council with executive powers could be established. The Branches in Australia decided, therefore, to replace the Federal Committee with a Federal Council, and on May 15, 1933, the Federal Council was incorporated under the *Companies Act* of New South Wales, as a company not for profit.

Figure II.

The present British Medical Association House (New South Wales Branch), which also houses the offices of the Federal Council.

The objects of the Federal Council are: to promote the medical and allied sciences, and maintain the honour and interests of the medical profession and to act for or on behalf of the Branches of the British Medical Association in Australia, in respect of matters affecting the profession as a whole.

Its membership of 15 is elected as follows: four members by the New South Wales Branch, three by the Victorian Branch, and two each by the other Branches—Queensland, South Australia, Western Australia and Tasmania.

The Federal Council has no direct income of its own, but to meet its general and other expenses the Branches are required to pay it such sum or sums as it may need, provided that the total in any year shall not exceed a sum equal to 25s. per member of the Branches.

Officers of the Federal Council are the President, the Vice-President and the Honorary Treasurer. Officials of the Secretariat are the General Secretary, the Assistant General Secretary and the Executive Assistant. The offices of the Council are situated at B.M.A. House, 135 Macquarie Street, Sydney (Figure II).

As a rule, two meetings are held each year. When urgent matters have to be considered, meetings are held oftener as required.

When a matter is submitted to the Federal Council for decision, it is first referred to the Branches for their opinions. These opinions are then sent to the Federal Council, which makes its decision at its next meeting, and unless, in the meantime, fresh light is thrown on the matter, the decision is binding on all Branches.

With the greater interest taken by the Commonwealth in community health, the Federal Council's work on behalf of the profession in Australia has greatly increased, particularly during the last twenty years.

Negotiations with the Commonwealth Government in respect of a National Health Service have been, and are, carried on by the Federal Council on behalf of the Branches. In the years immediately following the Second World War, with the full support of the Branches and of a united medical profession, it made a successful stand against the socialistic legislation introduced by the then Labour Government.

It has a representative on the National Health and Medical Research Council, a statutory body established by the Commonwealth Government in 1936. Its formation was strongly urged by the Council.

Under the ægis of the Federal Council the Australasian Medical Congress is held every three years. The Branch in whose area it is to be held is responsible for the actual organization. The Congress, being a scientific meeting, does not consider medico-political matters. It is designed to cater for both the specialist and the general practitioner.

On a Federal basis, special groups have been formed in several special branches of study.

The Federal Council is a member of the World Medical Association, and sends delegates to the General Assemblies. It also sends delegates to meetings of the British Commonwealth Medical Conference.

The medical profession in Australia is successfully organized, this being due very largely to the loyal support and cooperation of its members, and of the various professional bodies such as the Royal Colleges.

THE NEW SOUTH WALES BRANCH.

WHEN the New South Wales Branch came into existence in 1880, the British Medical Association in England was itself less than half a century old. The Branch originated at a meeting of interested doctors in February, 1880. On March 1 the first formal meeting was held, and the Association in London granted official recognition on July 7. The South Australian and Victorian Branches were also recognized in 1880.

In 1881 *The Australasian Medical Gazette* was founded as a commercial venture. Afterwards taken over by the Branch, it continued its useful career until, along with the Victorian *Australian Medical Journal*, it gave place to THE MEDICAL JOURNAL OF AUSTRALIA in 1914.

Before the Branch was founded an Australian Medical Association, with 87 members, existed from 1859 till 1868. But membership gradually dwindled, and at a meeting held early in 1869 it was decided to disband.

It is interesting to note that the Royal Society of New South Wales in 1876 established a medical section at which papers could be read and specimens shown. Though the New South Wales Branch of the British Medical Association had been formed in 1880, the Royal Society section continued its activities till 1899.

The Royal Society's Hall in Elizabeth Street was used by the Branch for its meetings for thirty-one years. Then, in March, 1911, the Branch moved to its own building, B.M.A. Building, a six-storey building which had been built on the opposite side of the street (Figure I). Here it continued its meetings and administrative work until the city's expansion required the building to be resumed. The Branch moved to its present *domus medica* in 1930. Thus it celebrated its jubilee in a building which could be regarded as one of the adornments of the city.

Membership in 1890 was 133. When the Elizabeth Street premises were occupied it had increased to 761, and in the jubilee year to 1684. It is at present 4186.

Any legally qualified medical practitioner resident in the State of New South Wales and registered under the *Medical Practitioners Act* of that State, is eligible for election to membership of the Branch. The annual subscription varies according to the type of practice, being eleven guineas for those in private practice, nine guineas for those who are whole-time members of the public services, including a university, or of any company or corporation, six guineas for those admitted to membership in the first year of registration, and four guineas for those retired or over seventy years of age. Members of fifty years' standing pay no subscription. Over 90% of the profession are members of the Association.

The New South Wales Branch, like other Australian Branches except the Victorian Branch, is a corporate body, having been registered in 1894 under the *Companies Act of New South Wales as a company not for profit.*

Whilst as a Branch of the British Medical Association its constitution must conform to that of the Parent Body, the New South Wales Branch, as are other Australian Branches, is practically autonomous.

Early in the century, with a view to organizing members for local purposes, it was decided (at the annual meeting in 1908) to approve the establishment of local medical associations. Eight of these already existed, and the number has increased over the years, standing now at 23—eight metropolitan and 15 country. In 1946, with the object of fostering closer relationship among local medical associations outside the metropolitan area, the Federation of Country Local Associations was constituted. The metropolitan local associations in 1948 formed a federation for a similar purpose. Though dormant for a few years, it has resumed activities.

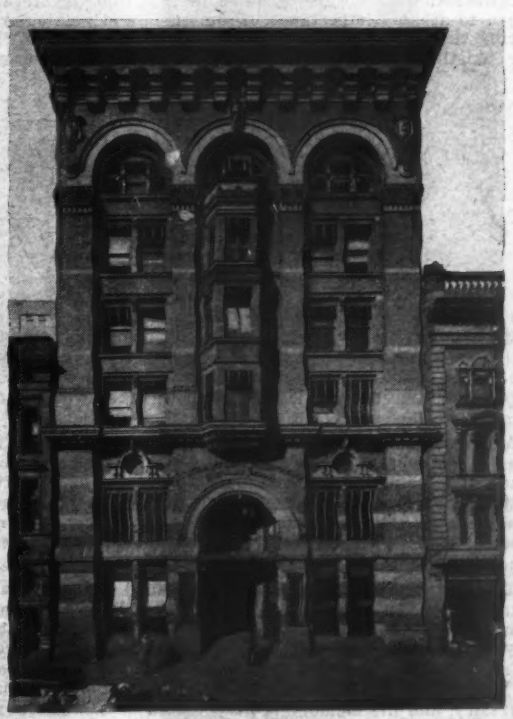

FIGURE I.
The first B.M.A. Building (N.S.W. Branch) in Elizabeth Street, Sydney.

In 1921, Special Groups for the study of special branches of medical knowledge—e.g., pædiatrics—were formed, and the number of such groups is now thirteen.

A short reference may appropriately be made to B.M.A. House. Its lines are in general modern, but there are mingled elements, in the detail, of Tudor style and ornament. The very individual design of the façade of 14 storeys is appreciated from such a vantage point as the lawn on the eastern side of Macquarie Street. The facing of terra-cotta, mainly buff, is given a variety of texture. Tradition is suggested by heraldic emblems: the gargoyles, for example, or lions which hold shields inscribed with the Association's badge.

The floor of the outer hall displays the badge in terrazzo and brass. Two rolls of honour of the Branch are placed on first floor walls and the names inscribed may be read by the light of a red lamp over each tablet.

A wall plaque above the entrance steps notes that the building was awarded, in 1933, the Architectural Medal of the Royal Institute of British Architects.

The foundation stone had been set by Sir Ewen Maclean, a Past President of the Association in Britain, who arranged for the presentation of a clock for the Robert H. Todd Assembly Hall. The Hall is notable for its display of portraits of former presidents of the Branch.

The library, now one of the most important medical libraries in the southern hemisphere, had its genesis in donations of books made by members, the books being in the care of the firm of booksellers, Messrs. Angus and Robertson. However, it was not until the new premises in Elizabeth Street were occupied in 1911 that the library began to assume importance. From then, and particularly during the last ten years, it greatly increased in size, till the existing accommodation on the first floor became inadequate. Accordingly it was necessary to extend the accommodation by using the adjoining Council Room as part of the library. This has meant construction of a new Council Room on the second floor.

The books and periodicals (excluding reprints, pamphlets and duplicate books and journals) in the library number approximately 11,000 and 16,000 respectively, and the number of current periodicals taken is 492.

The offices of the Association are on the first floor.

The upper ten floors are let to tenants, mostly medical practitioners.

The governing body of the New South Wales Branch is the Council, composed of 24 members elected annually by all members as follows: one to represent the women members, one to represent public (Government) medical officers, two to represent country local associations, two to represent metropolitan local associations and 18 to represent the general body of members. The work of the Council is carried out by standing committees which report to the Council.

The officers of the Council are the President, President-elect, Honorary Secretary and Honorary Treasurer.

Officials of the Secretariat are a Medical Secretary, Assistant Medical Secretary, Accountant, Executive Assistant and Librarian.

The British Medical Agency of New South Wales Ltd., which deals with the business side of medical practice —e.g., sale and purchase of practices, supply of *locum tenentes* and assistants, secretarial assistance, etc.—and the British Medical Insurance Company of New South Wales Ltd., which effects various types of insurance for members of the profession, and the Medical Benefits Fund of Australia were founded by the New South Wales Branch.

THE VICTORIAN BRANCH AND THE MEDICAL SOCIETY OF VICTORIA.

The Beginnings.

Medical graduates have played a not inconspicuous part in the social and political history of the State of Victoria—the second smallest of the Commonwealth in area, but in population the second largest, and in the eyes of all loyal Victorians the leading State of Australia.

As Lieutenant James Cook in *Endeavour* approached the eastern coast of Australia on April 20, 1770, a landfall was made at a point on the east Gippsland coast of Victoria, and it is a reasonable speculation that among the excited observers on that day was Surgeon Monkhouse, the first medical man to see the future State; but no landing was made at that time.

The first landing did not take place until eighteen years later, when in January, 1798, George Bass, assistant surgeon of H.M.S. *Reliance*, at the end of a remarkable voyage from Port Jackson in a 12′ whaleboat with a crew of six, landed at Western Port, an inlet on the South Coast of Victoria. He was the first doctor to set foot on Victorian territory, and his memory is perpetuated by a brass mural in the foyer of the Medical Society Hall in Albert Street, East Melbourne, with the following inscription:

> In memory of GEORGE BASS surgeon in H.M.S. Reliance who discovered Bass Strait in 1797-8 and accompanied Flinders in H.M.S. Norfolk, when Tasmania was first circumnavigated, 1798. Matthew Flinders, R.N., said of him: He was one whose ardour for discovery was not to be repressed by any obstacle nor deterred by danger.

On April 26, 1802, Matthew Flinders in *Investigator* explored the east and west shores of Port King (now Port Phillip Bay), and with him was Robert Brown, who was surgeon and botanist to the expedition—Victoria's second medical visitor.

The third was McCallum (his christian name is not recorded), who accompanied a survey party under the charge of Charles Grimes, the Surveyor-General of New South Wales, which on February 2, 1803, found the mouth of the river Yarra where it enters Hobson's Bay at the head of Port Phillip Bay.

Later that year, in October, Lieutenant-Colonel Collins with two ships, *Calcutta* and *Ocean*, landed at Sullivan's Bay, a few miles inside the entrance to Port Phillip, and established a settlement, which was abandoned in March, 1804. With Collins's party, which included 1400 convicts, were William J'anson, surgeon, Matthew Bowden, first assistant surgeon, William Hopley, second assistant surgeon, and Edward Brumley, surgeon in the *Calcutta*.

Collins, with the survivors of his party, moved to Hobart Town, and apart from landings by sealers and whalers, Victoria remained virtually undisturbed for twenty years until the exploration of Hume and Hovell, overland from Sydney, in 1824. They reached the coast west of Port Phillip, and their reports of the good pastoral country they had discovered aroused the interest of John Batman and others.

Edward Henty settled at Portland, not far from what is now the South Australian border, in November, 1834, and the next year, on June 7, 1835, Batman chose the present site of Melbourne as "the place for a village", and after revisiting Tasmania returned to the encampment on the Yarra on either November 8 or 9. With his party and acting as its manager was Barry Cotter, an Irishman with

a Glasgow qualification, who erected a house on the north-east corner of Queen and Collins Streets and became the new community's first doctor; all his predecessors had been transient visitors attached to official expeditions. A month after his arrival Cotter delivered the first white child born in Melbourne—the son of James and Mary Gilbert.

The year 1836 saw the arrival of Melbourne's second doctor, Alexander Thomson, who had pastoral interests in Van Diemen's Land. He was officially appointed the first Government Medical Officer at a salary of £200 *per annum*, but resigned within a few months and took up land near Geelong, playing a prominent part in the affairs of that locality. Cotter succeeded Thomson as Government Medical Officer, but in September, 1837, was supplanted by Patrick Cussen, a military surgeon who had been sent from Sydney. Slowly the settlement extended, and there was a steady influx of doctors from Britain who were attracted by population growth and the prospects of becoming land owners. Jonathan Clarke was the first official medical officer at Geelong; Edgar Lovell Byass was in practice in Portland in 1838, and George MacKay in north-eastern Victoria the same year; David John Thomas, David Elliott Wilkie, John Sproat and William Byam Wilmot (the first coroner) arrived in 1839; while 1840 saw the arrival of Godfrey Howitt, A. F. A. Greeves, Forster Shaw, Edward Barker, James Frederick Palmer and J. B. Clutterbuck.

D. J. Thomas, M.R.C.S., L.S.A., was the outstanding practitioner of those named, and was among the first in Australia to administer an anæsthetic (ether); this he did on August 2, 1847, for amputation of a forearm following a gun-shot wound. (There is a rival claim to priority for the administration of ether by Dr. Pugh of Launceston on June 7, 1847.)

Prominent in the political field was J. F. Palmer, M.R.C.S., who became Mayor of Melbourne in 1845, represented Victoria in the New South Wales Parliament in 1848, and was Speaker in Victoria's first Parliament and later first President of the Legislative Council.

In Victoria's first bicameral Parliament (1856), the Premier (W. C. Haines), the President of the Legislative Council (Sir J. F. Palmer) and the Speaker of the Legislative Assembly (Sir Francis Murphy) were all medical graduates.

The Port Phillip Medical Association.

By 1846 the population of the Port Phillip District of New South Wales had reached 32,879, and on May 16 of that year a meeting of doctors was held at the Prince of Wales Hotel in Little Flinders Street. The outcome of that meeting was the formation of the Port Phillip Medical Association:

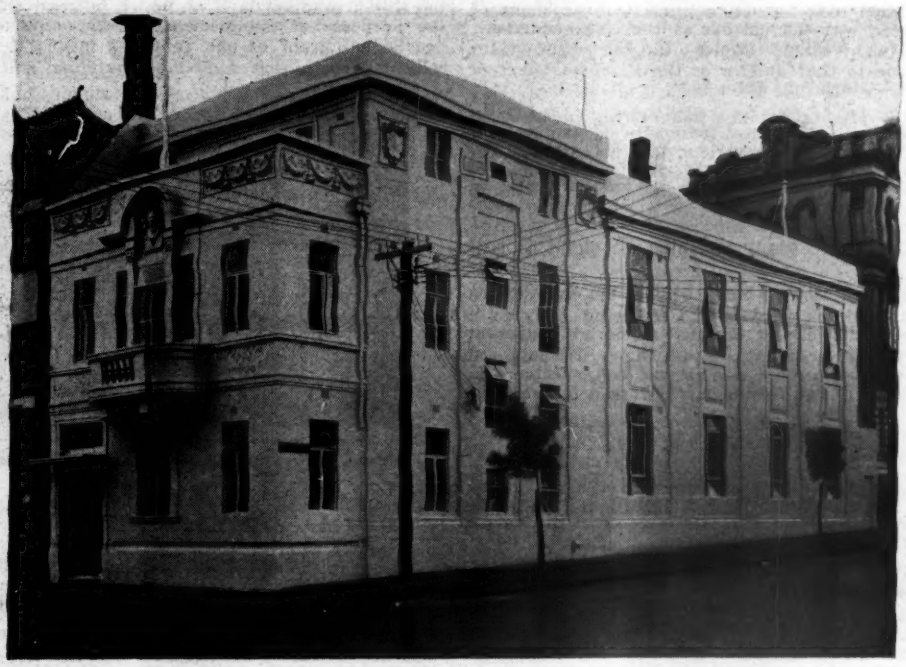

FIGURE I.
The Medical Society Hall and Headquarters of the Victorian Branch.

> The primary objects of this Association shall be the promotion of medical knowledge and a more free professional intercourse. The more special objects shall be the formation of a medical library and museum, the reading of original papers on medical subjects, the introduction of a code of medical ethics and the establishment of a greater uniformity in professional charges.

H. B. Graham (*vide infra*) has made the following comment:

> The definitive set of rules and regulations decided during the first few months of the existence of the Port Phillip Medical Association is of considerable interest; it was the outcome of discussions by this small group in a remote outpost of the far-flung empire and pre-dates the constitutions of the British Medical Association and the American Medical Association.

A scale of fees was also published, and it is of interest to note that the recommended fee of 10s. 6d. for a single visit remained unchanged for over 100 years.

Alas, it has to be recorded that all members did not obey the rules, and before long personal animosities and bickerings developed, membership dwindled and the curtain fell on November 20, 1851, with a pencilled note at

the end of the minutes of a meeting on that date: "Society dissolved, sold books, cleared up."

The Victoria Medical Association.

On May 7, 1852, a meeting of the medical profession was held at the Bull and Mouth Hotel, 44 Bourke Street East, Melbourne, followed by the formation of the Victoria Medical Association:

> The primary objects of this Association shall be the promotion of medical knowledge, a more friendly professional intercourse and, in general, the whole interests of the profession.

Dr. David Wilkie, who had been active in the affairs of the Port Phillip Medical Association, was elected President, and on July 19, 1852, the new association adopted a code of rules and regulations.

The association took an active interest in problems of the day, and as was the custom at the time, addressed "memorials" on various topics to the appropriate authorities. One to the "Judges of the Supreme Court of the Colony of Victoria" in July, 1854, pointed out:

> That the present practice and system under which the attendance of medical witnesses is required in criminal trials result in serious loss not only to the members of the profession who are subpœnaed but to the public . . . . That while such a system continues medical men may avoid cases in which their evidence is necessary and thus justice may often be defeated.

One hundred and five years ago, and the plaint is still heard!

Just as the law is slow to move, so does the civil service remain unchanged, as witness the following reply to a somewhat impassioned and lengthy memorial addressed to the Lieutenant-Governor, Sir Charles Hotham, in September, 1854, when there was an outbreak of cholera in Mauritius which, it was feared, might spread to Victoria:

> Government Offices, Melbourne.
> 15th Sept. 1854.
>
> Sir,
>
> With reference to the Memorial of the Victoria Medical Association of the 12th inst., I am desired by the Lieutenant-Governor to inform you that the subject has long been under consideration.
>
> I have the honour to be, Sir,
> Your most obedient Servt.
> (Signed) J. H. Kay,
> Private Secretary.
>
> Richard Eades Esq., M.D.

The Medical Society of Victoria.

In 1855, the Medico-Chirurgical Society of Victoria was amalgamated with the Victoria Medical Association, a revised set of rules was adopted and steps were taken to establish and publish the *Australian Medical Journal*.

Rule 1 provided "That the name of the united Society be the 'Victoria Medical Society'", and when the rules were revised in 1861, that rule was amended to read: "The name of the Society shall be 'The Medical Society of Victoria'."

In 1855 the Society was actively pressing for legislation in relation to registration of medical practitioners, and the first *Medical Act* was passed in 1858.

In 1859 a proposal to change the name of the Society to "The Faculty of Medicine" was advanced, but concurrent plans to develop a medical school in the University of Melbourne led to the abandonment of that proposal, and the medical school was opened in 1862.

The Victorian Branch of the British Medical Association.

In 1879 Dr. Louis Henry returned from England, with authority from the President of the British Medical Association to establish Australian Branches. (For some reason not recorded and apparently unrelated to the project to form Australian branches of the British Medical Association, an application by Henry for membership of the Medical Society was rejected.) On September 25, 1879, the Victorian Branch of the British Medical Association was established with 30 foundation members, and by the end of the year membership had doubled.

Fortunately many doctors maintained membership of both Society and Association, and eventually, in 1907, largely through the influence of Harry B. Allen (later Sir Harry Allen), Professor of Pathology in the University of Melbourne, the two bodies amalgamated. Since that date members of the Medical Society of Victoria have been members of the British Medical Association and vice versa, both bodies being governed by a common set of rules.

The Medical Society Hall.

In 1860, application was made to the Government of the day for a grant of land on which to erect a building for the purposes of the Medical Society of Victoria, and a provisional grant of one acre was made "if the Society will undertake that a suitable building will be erected

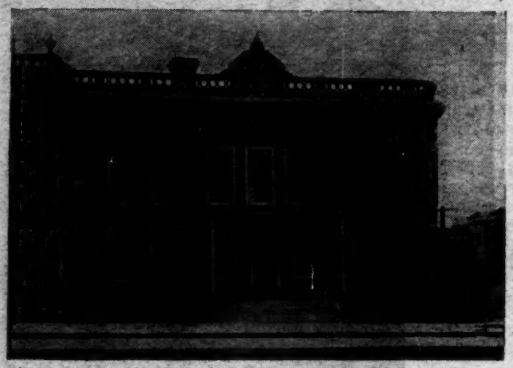

Figure II.
Mollison House.

. . . prior to the end of the year 1861 . . .". The site offered was in Lygon Street adjoining that now occupied by the Trades Hall, and the offer was accepted by the Society.

Unfortunately, because of disagreement among members and the failure of attempts to establish a building fund, the undertaking to erect a building was not honoured, although it was not until 1866 that the Office of Lands and Survey finally withdrew the offer of the site for non-fulfilment of the conditions under which it had been granted. What a tragedy! Today an acre of land in Lygon Street would be worth a fortune—and no parking problems.

So the Society continued to meet where it could, not infrequently in the hall of the Royal Society (now shared by the Royal College of Obstetricians and Gynæcologists); but in 1876 (the actual Deed of Grant was not issued until 1882) the Crown agreed to make a grant of land in Albert Street, East Melbourne, "to provide a Site for a Hall and library for the use of the Medical Society of Victoria and for other Scientific purposes . . .".

A building erected on that site was opened on January 16, 1878, and was used as the Hall of the Society until it was demolished and replaced by the present Medical Society Hall, which was opened in 1925.

Today, since the membership is over 3000, the Hall is inadequate, and the Society has acquired property on the corner of Albert and Lansdowne Streets, East Melbourne, part of which has been converted to professional rooms, known as "Mollison House", so perpetuating the name of Crawford Henry Mollison, who served for over fifty years as Honorary Treasurer of the Medical Society of Victoria. A third Medical Society Hall will, it is hoped, rise on this new site.

Present-day Organization of the Medical Society of Victoria and the British Medical Association (Victorian Branch).

The affairs of the Society and the Branch are controlled by a joint Committee of the Society and Council of the Branch with a membership of 39—five Trustees of the Medical Society, the Director for Victoria of the Australasian Medical Publishing Company Limited, a nominee of the Victorian Medical Women's Society, 14 members elected by the general body of members and 18 elected as subdivisional representatives.

The State is divided into "subdivisions" on a geographical and medical-population basis, with eight subdivisions in the country and eight in the Melbourne metropolitan area, and members of each subdivision elect a representative to Council with the exception of the "Melbourne Subdivision" (consisting mainly of specialists), which elects three representatives.

Council elects the office bearers—president, two vice-presidents, chairman, honorary secretary, honorary treasurer and honorary librarian—and they, with the immediate past-president, form an executive which meets one week prior to the monthly Council meeting to determine order of business, etc., to be submitted to Council.

Each year several sub-committees—ethics, organization, hospital, legislative, etc.—are appointed, and they report to Council on matters referred to them.

Special machinery has also been devised to convene, at the instigation of Council, a "Branch Convocation", when decisions on basic policies become necessary, and the opinion of members may also be sought by referendum.

Matters of Commonwealth-wide concern are dealt with by the Federal Council of the British Medical Association in Australia, to which the Branch Council appoints three representatives.

Members with special interests have the right to form "special groups", which may be of limited membership or open to all members of the Branch, and several such groups exist.

Each year a scientific programme is arranged, consisting of lectures, "clinical" meetings in hospitals and demonstrations in University departments, and on three or four occasions meetings are held in country centres.

Council also nominates representatives to many Government-appointed committees dealing with matters of medical interest, and to bodies concerned with social and welfare work.

The Association has also been responsible for the establishment of the British Medical Insurance Company of Victoria Limited and the British Medical Agency—business ventures which have been of benefit to the medical practitioners in Victoria.

Acknowledgement.

The writer is deeply indebted to Dr. H. Boyd Graham, who published his researches into the history of medical organizations in Victoria in an article in THE MEDICAL JOURNAL OF AUSTRALIA of August 16, 1952; that article has been freely drawn upon in preparing the present account.

THE SOUTH AUSTRALIAN BRANCH.

THERE are traces of two medical societies having been established in South Australia, and having passed out of existence, during the 43 years which elapsed after the Proclamation of the Province on December 28, 1836, prior to the formation of the South Australian Branch of the B.M.A. The traces referred to consist (*a*) in the announcement of the gift of medical books to the Public Library when the first medical society was disbanded in the year 1856, and (*b*) of a surplus of £197 which remained in hand when the "South Australian Medical Association" was dissolved. With this surplus it was decided to create a benevolent fund, to administer which three trustees were appointed, and thus the present "Medical Benevolent Association of South Australia (Incorporated)" was established.

The "South Australian Medical Association", according to a legend, failed to justify its existence in the eyes of some younger members of the profession in the city of Adelaide because, apparently, it preferred to devote its meetings to wrangling over the ethical shortcomings of its members rather than to discussing the brilliant advances in medicine and surgery which marked the seventies of last century. The thoughts of the younger men turned naturally to the British Medical Association, of which no Branch had as yet been established under the Southern Cross, and Dr. Thomas Cawley wrote in 1879 to the General Secretary (Mr. Francis Fowke), asking for information as to the procedure to be adopted in the formation of such a Branch. Before any answer could be received, a preliminary meeting was held on May 30, 1879, at the house of Dr. William Gardner, who even then, though only 33 years of age, was regarded as the leading surgeon of South Australia. There were present at this meeting, besides the host, Dr. Astles, Dr. Baily, Dr. Cawley, Dr. Clindenning, Dr. Corbin, Dr. Hawkins, Dr. Hicks and Dr. Way. It was resolved that a new medical society should be formed, devoted chiefly to the discussion of original papers, the exhibition of patients and of pathological specimens, and the advancement of medical and surgical science in general. Further, on the motion of Dr. Cawley, it was resolved that, if practicable, this new society should be a Branch of the British Medical Association. A provisional committee of five was formed to issue circulars to the medical profession throughout the whole Colony, which then included the present Federal or Northern Territory, and to convene in due course a general meeting. No time was wasted, for the meeting was held at the South Australian Club Hotel on June 19, 1879, when 30 doctors were present, the chairman being the doyen of the profession in Adelaide, Dr. William Gosse. He was chosen as the first president of the new Branch, and Dr. T. W. Corbin as its vice-president. The honorary secretary appointed was Dr. W. L. Cleland, for many years superintendent of the Parkside Lunatic Asylum, the honorary treasurer being Dr. Hawkins. Three members of the Council were elected, by-laws were formulated and an Ethical Committee was chosen. To celebrate this important event it was only natural that an inaugural dinner should be held in July. There was some feeble opposition by the "die-hards", led by Dr. Seabrook and Dr. McIntyre, who voted against the formation of the new society. Others qualified their support by insisting that the suppression of unqualified practice by means of legislation should be one of the platforms of the new society. A few of the defunct association also kept aloof from the new Branch of the British Medical Association. The census that had been taken revealed that there were only six members of the profession in the Colony who were already members

of the British Medical Association. Their services were called into requisition to sign the nomination papers of some 30 others, who were duly elected on October 15, 1879, by the Committee of Council in London. In sending an intimation of this election to Dr. Cleland, Mr. Fowke enclosed a couple of resolutions, from which it may be surmised that the geography of Australia had not been studied very deeply at B.M.A. headquarters, for in the first resolution it was stated that the 30 new members had "been signed for by three members of the Association in New South Wales". The signatures were really those of two Adelaide men, and of Dr. W. T. Hayward, who came down specially from Riverton to sign as the third sponsor.

Figure I.
The Hindmarsh Square building, originally owned by the South Australian Branch.

The second resolution expressed gratification at the proposal of the members in New South Wales to form a second Colonial Branch at Sydney. The report of the proceedings published in the *British Medical Journal*, however, read:

> That in recognising the intimation of the intention of Members of South Australia to form a second Colonial Branch the Committee of Council expresses their fullest satisfaction at such intention, and will gladly recognise such Branch when formed according to the laws of the Association.

It was not till July 7, 1880, that the petition of the 22 South Australian members was considered and formal recognition of the South Australian Branch given by the Committee of Council. New South Wales was recognized on the same day, and Victoria on August 10, 1880. There were at this time some 108 names on the register of duly qualified practitioners in South Australia, and the Branch numbered 37 members at the end of the first year of its existence, June 30, 1880.

The Branch meetings were at first held in the evening in a classroom of the newly-established University of Adelaide, and later at Morialta Chambers, Victoria Square. For several years the place of meeting was the old Board Room of the Adelaide Hospital, to be followed by migration to a lecture theatre of the University of Adelaide. The average attendance in the early days was eight or nine members, whilst 15 constituted a large meeting. Transactions of the Branch were printed, excellent pathological drawings were contributed by Dr. Dunlop, the then Senior House Surgeon, and debates were carefully reported by Dr. Cleland. In 1881 the *Australasian Medical Gazette* of Sydney undertook the publishing of the reports, of which reprints were issued to the members for some years.

In the jubilee year of its foundation, the membership of the Branch was in the region of 400.

One outstanding feature of the Branch's activities during its early years was the inauguration in 1887, at the suggestion of Dr. Benjamin Poulton, the first secretary, of the series of Intercolonial Medical Congresses. After the federation of the Australian States in 1900, the Congress became known through its association with New Zealand as the Australasian Medical Congress, and subsequently came to be conducted under the ægis of the British Medical Association.

The credit is also due to the South Australian Branch for being the means whereby women were first admitted to membership of the Association. In the University of Adelaide women had equal privileges and rights with men. In December, 1891, Miss Laura Fowler graduated as M.B. and Ch.B. At the instigation of the then secretary of the South Australian Branch (Dr. A. A. Lendon), but rather against her own inclination, she applied for membership

Figure II.
"Elizabeth House", later erected on the site formerly owned by the British Medical Hall Company on North Terrace, Adelaide.

of the Association. At that time the rule read as follows: "No female shall be eligible for election as a Member of the Association." The application came before the Branch Council, and it was decided to give the members of the Branch an opportunity of discussing the abstract question whether it was desirable or not to admit women to membership of the Association. The matter was accordingly brought up at the meeting of the Branch on February 18, 1892. In moving a resolution that the meeting was of opinion that the time had arrived when it was desirable to alter the Articles of Association so as to allow

of the admission of women to membership, Dr. Lendon pointed out that when this prohibitive regulation was adopted in 1880, there was no provision for granting a licence or diploma to women in England, and no provision for its registration if it was obtained, as such a diploma could be, in Scotland or Ireland. Since then the University of London and other bodies had opened their portals to women, and degrees were given to them both in Great Britain and in her Colonies, registrable by the General Medical Council. The logical and forcible plea Dr. Lendon put forward for justice to the other sex appealed to the majority of those present; but in a matter of such importance it was thought only right that a plebiscite of the whole Branch should be taken. On March 24, in anticipation of a discussion, an unusual number of irreconcilables "dug themselves in" in their last trench—namely, the ballot—so that Miss Fowler's election to the Branch was actually deferred till the arrival of the new Articles of Association from England. Miss Fowler (afterwards Mrs. Charles Hope) may not have actually been the first woman elected a member of the Association, but she was the immediate cause of the women's being admitted. Again, the South Australian Branch may not have been the first Branch to agitate for the admission of women; but it was undoubtedly the strong case made out by our Branch that induced the annual meeting of members at Nottingham to alter their constitution. There is little doubt that it was a repercussion of the Laura Fowler controversy which led Dr. E. C. Stirling, a member of the Branch and also of the South Australian legislature,

FIGURE III.
"Newland House", 80 Brougham Place, North Adelaide.

members attended. The report of the secretary was to the effect that circulars had been sent to the 96 members of the Branch then actually in the Colony, and that 75 replies had been received. Forty-six members were favourable to the change, 20 disapproved of it, whilst nine were indifferent, so that, when the indifferent votes were excluded, there was a clear majority. On a further motion by Dr. Lendon that the feeling of the Branch should be reported to the Council of the Parent Association, there was some considerable opposition and an amendment that the discussion should be adjourned *sine die;* but the original motion was carried without any more disastrous result than the resignation of a member who, at the age of 75, remained a bachelor and presumably a misogynist. The matter came before the annual meeting of the Association at Nottingham in 1892, and although it had been turned down fourteen years previously by a large majority, it was now accepted as a reasonable reform. Formal approval of the Council and the necessary alteration of the Articles of Association followed, and soon after the result had been cabled out to Adelaide, the Branch Council proceeded to elect Miss Fowler a member of the Association (October 20, 1892). The matter of her election as a member of the South Australian Branch was a separate question, and the to introduce early in the eighteen-nineties a bill providing for the grant of the franchise to women on the same terms as those enjoyed by men. It is a notable historical fact that South Australia was the first self-governing unit of the British Empire to give the vote to women.

The South Astralian Branch early made an attempt to divest itself of its responsibilities with regard to lodge practice, and this responsibility was assumed by a separate "Association of the Registered Medical Practitioners of South Australia". Later the Branch resumed charge, and the discussions with respect to the relations of the profession to their lodges, as well as to the chemists, have for a third of a century engrossed an immense amount of the Council's time and energy. When it released this function to the British Medical Association, the Association of the Registered Medical Practitioners of South Australia became converted into the Medical Defence Association, which has been an immense boon to the profession.

The scientific work of the Branch probably differs but little from that of any other Branch either in Great Britain or beyond the seas; but the modern urge to specialize has led to the formation within the Association or the Branches of groups or sections dealing with special

spheres of medical and surgical practice. In South Australia these meet at the University, or at one or the other of the hospitals in Adelaide or the larger country centres.

When, largely owing to the stimulating enthusiasm of Dr. C. T. C. de Crespigny, the Institute of Medical and Veterinary Science was erected, a spacious lecture hall, known as the Sir Joseph Verco Theatre, was included. Most of the meetings of the Branch have been held there since.

Not long before the first World War, the South Australian Branch Council, having noted the advantages the N.S.W. and Victorian Branches enjoyed from the possession of executive offices and a commodious hall for scientific meetings, decided to follow suit. The British Medical Hall Company was incorporated, with a capital of £7000 furnished by the Branch and a section of its members. A building of two storeys, with good office accommodation and a commodious hall and annexes in Hindmarsh Square, was purchased for the moderate sum of £5500 (Figure I). Some years after the war, the Branch decided to purchase land on North Terrace adjoining the Electricity Trust Building. The Hindmarsh Square property was sold for £11,000, of which £8000 went to buy the vacant block. Accommodation for the executive of the Branch and the medical agency was secured at a reduced rental in Verco Buildings, North Terrace. After fruitless efforts to induce the Branch to consent to the erection of the building, for which the Hall Company had obtained plans, the directors decided to accept £14,500 for the land and seek a suitable site in North Adelaide, where ample parking space would be available. (The ultimate owners of this land have erected one of the most imposing buildings on North Terrace on the site (Figure II) and desired to name it after the chairman of the British Medical Hall Company who, in loyalty to the B.M.A., declined the honour. The owner then named it "Elizabeth House", an indirect compliment which Sir Henry Newland may well regard as a greater one than if the building had borne his own name.) A low-lying site in Kermode Street was purchased in North Adelaide for a mere £1650. Not long afterwards, a fine elevated site on Brougham Place, on which stood a substantial house with two storeys, was bought at auction for £11,500, and the low-lying block was sold for double what it had cost. The front elevation of the house has been made more imposing by the addition of doric columns and a substantial entablature (Figure III). Offices for the B.M.A. Executive, a Council Chamber and three medical suites have been provided. The Branch Council has named the building Newland House; but Sir Henry Newland, made wary by past events, has declined to have his name placed on the entablature until the foundation stone of the projected hall is laid. The hall for the Branch is still in the offing. The Hall Company submitted plans and financial proposals approved by a leading life insurance company but the Branch remained refractory, and the circumstances made it obvious that the only course was for the Branch to acquire by gift or purchase all the shares of the Hall Company, which should then go into liquidation. That course has been followed. To enable the medical agency of the Hall Company to be carried on in association with other activities in the financial interest of the members of the Branch, a company entitled B.M.A. Services Ltd. has been incorporated. The Branch Council has appointed committees to secure plans and specifications for a hall and accessory buildings, and to obtain the finance necessary. Plans and specifications for a hall are nearly complete, and tenders are about to be called for. After the completion of the hall, the Hall Company had in mind the erection of a four-storey block of modern consulting suites. There is a great demand for such a building. Brougham Place has become the Harley Street of Adelaide. There are many doctors on North Terrace who can rent their rooms only on a monthly tenancy, and would hasten to move to Brougham Place were accommodation available.

In conclusion, it should be mentioned that in accordance with the common practice of scientific bodies, the Branch Council is fully alive to the necessity of ministering to the creature comforts of members. A kitchen and servery have been planned in the vicinity of the foyer, and above this there is to be a club room for members with comfortable chairs and a servery at the eastern end. Recent research having shown that habitual physical work, which the medical profession lacks, is the best protection against coronary thrombosis, maybe the Council will view favourably the provision of a squash court and a prophylactic treadmill.

THE QUEENSLAND BRANCH.

THE new State of Queensland was only twelve years old when the Queensland Medical Society was formed in Brisbane in March, 1871. The eleven members were: Kearsey Cannan (president), Hugh Bell (treasurer), Joseph Bancroft (secretary); William Hobbs, Robert Hancock, Kevin I. O'Doherty, J. J. Mullen and Ronald Gunn (committee); also Dr. Lossberg, Dr. Headley and Dr. Candiottis. All are shown as having paid their £1 1s. subscription. The society lasted for only nine months. It became disorganized in December, 1871, apparently in consequence of one member's attempting to open a discussion of a public nature on the relations between the medical profession and chemists with reference to prescribing and dispensing. There is no minute book of the society to be found. The balance of its funds (£5 16s.) had increased by interest to £11 11s. 3d. when it was eventually passed on to the Medical Society of Queensland.

The Medical Society of Queensland and the Queensland Branch of the British Medical Association.

The second attempt to form a medical society in Queensland took place in 1882. A group of doctors met at the home of Dr. Rendle, and as a result a circular signed by P. Smith, M.D., called a meeting on June 1, 1882, in the Temple Buildings, Queen Street, Brisbane. Present were Dr. Cannan, Dr. Hancock, Dr. Little, Dr. Taylor, Dr. Rendle, Dr. Concannon, Dr. Purcell, Dr. Cutfield, Dr. Smith, Dr. Jackson and Dr. Marks. Dr. Bancroft sent his apology, and suggested that they form a branch of the Philosophical Society. A motion to form a branch of the British Medical Association was lost because of the necessity to subscribe to the *British Medical Journal*. (At a later meeting is was also found that 40 members were necessary to form a branch of the B.M.A.) The meeting eventually decided to form a medical society in Brisbane, and this was done at a meeting in the Temple Buildings on July 5, 1882. Dr. K. I. O'Doherty was elected president and Dr. P. Smith secretary and treasurer at a meeting in the rooms of the Philosophical Society on August 2. At this meeting it was again proposed to become a branch of the B.M.A., and again the *British Medical Journal* was the ostensible stumbling block.

Dr. Smith resigned his secretaryship at a meeting on March 14, 1883, as he was going to England. Interest

in the young society lapsed, and no further meetings were held until October, 1886. The lack of interest may have been due to the loss of an active secretary, but Dr. Rendle, when secretary later on, made a note that he understood it was due to a discussion on ethics at the March meeting and to the raising of the subscription to £2 2s. This is no doubt correct, as there is a minute of a meeting of the re-formed society in 1886 in which it is stated that the members would abstain from discussion on ethics or on non-scientific matters for two years. From then on—that is, from October, 1886—the Medical Society of Queensland continued to function until its 153rd general and twelfth annual meeting on December 5, 1899.

It had previously been resolved by the Medical Society of Queensland and the Queensland Branch of the B.M.A. that they would amalgamate on January, 1, 1900. This amalgamation duly occurred.

In 1900, in the sixth annual report of the Queensland Branch of the British Medical Association, there appears this item:

> In the early part of the year in reply to a request of Dr. Tom Bancroft for a scientific grant to assist in the study of filaria metamorphosis a sum of £7 was voted to him. This is the first time in Queensland that a sum has been granted by a medical society for original scientific investigation.

Perhaps this is the place to quote Judge Paul in the Toowoomba District Court on April 23, 1894, in Garde *v.* E. C. Schmid: "Surgery is an exact science; medicine is a game of chance."

In 1926 the Queensland Branch of the B.M.A. was registered and incorporated under the *Companies Acts*, 1863-1913. Of the eight signatories Mrs. Myra Spooner, who recently resigned as secretary of the Branch, is the sole survivor. She indeed witnessed and assisted the phenomenal growth of the Branch over a period of 40 years, during which Queensland's population expanded from approximately 700,000 to 1,400,000, and the membership of the Branch from 280 to 1222.

FIGURE I.

B.M.A. House, Brisbane: Eastern aspect and front entrance. Part of the library is in the tower.

The B.M.A. had already given permission in 1893 for a Queensland Branch to be formed, and on Wednesday, May 30, 1894, the inaugural meeting of the Queensland Branch of the B.M.A. was held in Brisbane, in the form of a banquet in the Masonic Hall, Alice Street. During his presidential address, Dr. the Honorable W. F. Taylor, M.L.C., said that credit for forming the Branch was largely due to Dr. Jackson and Dr. Peter Bancroft, who had in 1892 sought the cooperation of those willing, and had formed the Queensland Medical Association with a view to its becoming a Branch of the B.M.A. Dr. Taylor in his address drew attention to the apathy, not only of legislators and the public, but of the medical profession itself, regarding "the contagious nature of consumption and tuberculous disease of the lungs". Consumptives, he said, occupied the general wards in hospitals. His Excellency the Governor, Sir Henry Norman, was present at the inaugural meeting, and appeared much interested in the microscopic slides showing tubercle bacilli which were demonstrated by Mr. Pound, of the Queensland Stock Institute.

A monthly meeting of the Branch was held in the Courier Buildings on June 14, 1894. At this meeting Dr. Jackson presented a case of microcephalus and a case of imperforate hymen in a child. Dr. Thomas Bancroft gave a paper entitled: "Some Further Observations on the Physiological Action of Snake Venom together with a Reference to the Strychnine Cure of Snake Bite."

Branch headquarters were moved, in 1937, from small premises in Adelaide Street in the heart of the city, to a pleasant two-storey wooden building at the upper end of Wickham Terrace, opposite the old convict-built mill. This finally proved inadequate also, and in 1957 the Branch moved again to what will no doubt remain its permanent headquarters.

The new B.M.A. House in L'Estrange Terrace, Kelvin Grove, occupies a commanding position with extensive views of river, bay and mountains. A dignified building of granite, it is constructed to take full advantage of cooling north-eastern breezes in the summer and the wonderful Queensland sunshine in the winter. Although it is one and a half miles from the centre of the city, it is near to the Medical School and the Brisbane Hospital, and more easily accessible to members travelling by motor-car than a building in a more central position would be. The spacious grounds with lawns and gardens provide room for parking cars at ordinary times, and for social events on special occasions. There are two floor levels. The upper one is occupied entirely by the Queensland Branch, and provides office space for Secretary and staff, council chamber, committee room, library and reading rooms. The lower floor accommodates the British Medical Agency, the University of Queensland Post-Graduate Medical Education Committee

and the Queensland Branch of the Australian Dental Association.

At the opening ceremony, which took place at the time of the annual meeting in August, 1957, some 350 members and their wives and visitors were entertained to dinner in the house and grounds. The Branch is justly proud of its new headquarters, which already conveys the calm and leisurely atmosphere of a good medical club, something that the cramped offices of the former days could never achieve.

The Organization of the Queensland Branch.

Some details of the organization of the Branch may well be given at this stage.

The Queensland Branch of the British Medical Association, like the Branches in the other States of Australia and in other countries of the British Commonwealth, is an integral part of the Parent Body in Great Britain, to which it bears the same relation as do the divisions in that country. Like the latter, it appoints delegates to the annual meeting of the Representative Body, thus sharing in the formulation of the policies of the Association as a whole. It is bound by the constitution and by-laws of the Parent Body, but, with the consent of the Council of that body, it has the power to alter by-laws and frame new ones to suit local conditions. Again, provided there is no gross conflict with general policy, it has complete independence with regard to all matters of purely local import. Charged with administration and control is a Council consisting of president, past president, president elect, secretary and 14 members. Half the ordinary members retire annually and, together with new nominees, are eligible for election by the general body of members throughout the State. In the event of more than one nomination, the president-elect and secretary may also be submitted to ballot; but in accordance with precedent, this rarely occurs. From the Council a chairman, honorary treasurer and two representatives to the Federal Council of the B.M.A. in Australia are appointed. Meetings are held fortnightly, and State-wide business is disposed of. To lighten the load on the Council, an organization committee meets three days before each Council meeting and deals with matters which are not controversial or contrary to adopted policies. For special purposes other subcommittees are established from time to time, and all submit their recommendations to the Council before implementation. Virtually all negotiations with the Government, departmental bodies, etc., are carried out by the Council, with resulting uniformity in agreements throughout the land.

For the convenience of country members, local associations, 15 in all, have been established with the object of promoting the scientific, medico-political and medico-ethical interests of the group. Each such local association draws up its own rules (which, however, must be submitted for the Council's approval), conducts meetings and furnishes to the Council annually a report of its proceedings. Each also appoints delegates to a convocation between local associations, specialist groups and the Council, which takes place twice each year. In this way members in remote areas are able to bring their needs and their opinions to the direct notice of the Council.

A very important function of the Council is the preservation of a high standard of ethics amongst members. For this purpose an ethics committee, the members of which are by tradition past presidents or senior members of the Branch, meets when required. Its activities are confined to disputes and complaints between members of the Branch, as its has no statutory power and therefore no authority to adjudicate where non-members or patients are involved. These latter are not subject to the by-laws, and any adjudication against them might involve the Council in litigation. It is pleasing to record that this is not a busy committee, which is a tribute to the generally high ethical behaviour of members. The prescribing of fees is limited to agreements with Government and semi-Government departments. Fees in private practice are a matter for arrangement between doctor and patient, and this applies even when the patient is insured in accordance with the National Health Scheme (fully described elsewhere by the General Secretary of the Federal Council). Nevertheless, excessive ove charging by doctors is, to a degree, controlled by a medical fees tribunal. A patient submits a complaint concerning fees to the Secretary, the complaint is referred for adjudication, and the findings are transmitted by the Council to both parties. Assistance to needy medical students is available from the Medical Students' Loan Fund, supported by annual voluntary donations from members.

Subsidiaries of the Branch.

To serve the more material needs of the profession, companies have been established, and these have become indispensable subsidiaries of the Branch. The Queensland Medical Finance Company provides funds for the young doctor, to assist him in purchasing or establishing a practice and such accessories as house and motor-car. An economic rate of interest is charged on loans, and many young doctors are grateful for the assistance given.

The British Medical Agency of Queensland, the largest subsidiary, provides for the medical profession, at a moderate profit, almost all necessary commodities. Surgery equipment, instruments, stationery and furniture are only a few of the items supplied. The Agency also deals with insurance, the sale and purchase of practices, the provision of *locum tenentes* and the arranging of assistantships and partnerships. It is a growing business organization with a directorate of doctors, which serves the needs of the profession from almost every angle.

The Branch and the Hospitals.

Through the years the Branch has always maintained an unwavering interest in the conduct of the State's hospitals. These institutions are governed by hospital boards, the members of which are appointed by the Government. In spite of continued pressure and agitation by the Branch, Governments have consistently refused to avail themselves of the services of medical men and women in the administration of organizations in which their knowledge and experience must have inestimable value. It has been a source of great satisfaction and pleasure to the Branch that, during the past year, a wise and discerning Government has seen fit to reverse this policy, so that members of the Branch are now serving on the boards of some of the largest hospitals in the State.

Medical Politics.

In recent years, since the advent of Government determination to introduce schemes for the socialization of medicine, medico-political matters have been the Council's main concern. Planning by the Federal Government on a nation-wide basis has been carefully watched by the central body of the Association in Australia, the Federal Council, on which this State is represented by two members, appointed annually.

The Branch and Other Bodies.

Interest in scientific bodies is not lacking, and so a representative is appointed annually or otherwise to such bodies as the Queensland Institute of Medical Research, the Queensland Radium Institute, the Queensland Health Education Council, the Faculty of Medicine of the University of Queensland and others. There is also a representative to the Flying Doctor Service, which serves the medical needs of the far out-back where resident doctors are not available. The Health Education Council maintains regular public instruction in health matters by means of radio, newspaper and other forms of publicity. Although not constituted within the British Medical Association, the Medical Defence Society of Queensland is an affiliated body, in which all registered medical practitioners in Queensland are eligible for membership. All members of its council are active members of the Association and the liaison between the two councils is very close. Members of the society, for the small annual fee of 10s. 6d., are entitled to legal advice in the case of actions taken against them in relation to professional

practice, and at the discretion of the council the expenses of defence may be met. For protection against suits for damages, however, it is a condition of membership that insurance must be effected with an approved organization and through the office of the society. At the moment, an arrangement exists with the Medical Protection Society in Great Britain, though a few members have elected to insure themselves elsewhere.

"The Promotion of the Medical and Allied Sciences."

In its planning for the future, the Branch Council has as its first objective those outgoing activities broadly defined as "the promotion of the medical and allied sciences". In Queensland such activities relate particularly to matters affecting the public health. Here the Association has a special contribution to make, both by reporting what its members (who comprise approximately 93% of all doctors in private practice) discover to be the needs of the community, and by providing the organization

FIGURE II.
B.M.A. House, Brisbane: Part of the northern end.

through which certain policies and health campaigns can be carried out.

A pattern of regular conferences between the executive officers of the Branch, the Minister for Health and the Director-General of Medical Services has been established during the past two years, and will be continued. The two last-mentioned are members of the Association, and at these informal conferences its has been found possible to iron out grievances and discuss mutual problems in a friendly spirit. It has been suggested that B.M.A. influence in other matters concerning the health of the community might be extended by holding similar conferences from time to time with Trades Hall leaders and representatives of business and industry.

As has been stated above, two members of the Association have been appointed during the past twelve months to the Brisbane and South Coast Hospitals Board, and certain others to hospital boards in country districts. This marks the end of a long era during which, under successive Governments, doctors were regarded merely as employees meriting no special share in hospital management. The Branch continues to press for the inclusion of medical men on all hospital boards in the State.

For the research worker library facilities are provided, and through THE MEDICAL JOURNAL OF AUSTRALIA and the scientific meetings of the Branch, an opportunity is extended to him to publish his findings; but except in such ways, the organization of medical research is beyond the scope of the B.M.A. in Queensland, and is not regarded as one of its functions.

Post-graduate training for its members is, however, a special responsibility of the Association, and future plans envisage an extension of this work. At B.M.A. House a substantial sum has recently been voted for annual additions to the Library. Obsolete books are discarded as new publications become available, and every effort is made to maintain a compact, up-to-date library of books and periodicals. Photostat equipment has been purchased, and copies of any article in the available medical literature can now be prepared and sent on request to country practitioners for a nominal sum. By way of the Post-Graduate Medical Education Committee (a joint B.M.A. and University body), tape-recordings of addresses given in Brisbane by visiting lecturers are dispatched to country associations and groups, and specialists are sent regularly from Brisbane to lecture in country centres. During 1958, no less than 48 lecturers were sent to 16 country towns for this purpose. It must be borne in mind that many country doctors in Queensland work in great isolation. Altogether 45 towns have one medical practitioner only, usually a young man, whose nearest colleague may be fifty miles or more away. Arrangements recently concluded with the Minister for Health and the Hospital Board for country practitioners to participate in the work of the Brisbane Hospital for short salaried refresher courses now bring active post-graduate work within the reach of these isolated doctors.

"The Promotion of the Honour and Interests of the Profession."

In this and other ways the Branch Council seeks its second objective — the promotion of the "honour and interests of the Profession" — believing that by so doing it is helping the community at large. The Council is concerned, as it has always been, to preserve private

FIGURE III.
B.M.A. House, Brisbane. South-east corner and tower.

medical practice. It is strongly represented on the management committee of the Medical Benefits Fund of Australia, which it was instrumental in establishing. It believes that, through voluntary insurance of this sort and the cooperation of medical men, the Australian citizen has one of the best medical services in the world. Constant vigilance is maintained to guard the private practice of its members, and to counter the political moves that are made from time to time in the direction of a nationalized medical service. A long struggle with the State Government Insurance Office is an example of this. An attempt had been made to fix fees payable for the treatment of injured workers, and a two-year campaign followed before it was admitted that the gazetted schedule indicated no more than the amount of refund payable to the injured worker by the office, whereas the fee charged remained a matter for arrangement between patient and doctor. The agreement arrived at is an excellent example of the value of negotiations by a central body, and further justifies a policy which has repeatedly

proved to be in the best interests of the profession. The remuneration offered to medical officers employed in hospitals and elsewhere has always been watched in the past and is likely to be as closely scrutinized in the future, the principle being that these responsible posts will attract men of the right quality only so long as the salaries attached to them compare favourably with what can be earned in other fields.

The Branch itself is in the fortunate position of numbering in its membership a very high proportion of all the doctors registered in Queensland. The majority of non-members are recent graduates still working in hospital, or new arrivals in the country, or elderly and retired doctors. The high rate of membership is maintained by encouraging senior medical students to join as associate members, by sending to each new graduate a letter from the President explaining the advantages of joining the B.M.A., and by inviting applications from medical practitioners who are newcomers to the State.

A scheme for helping doctors to provide for their old age, known as the Medical and Associate Professions Superannuation Plan, was started two years ago. The ordinary doctor finds it hard to save very much, receives no pension on retirement and as a rule has little time or skill for the stock market. In such circumstances a reliable fund, to which regular contributions can be made that are tax-free under certain conditions, has much to commend it. These then accumulate at compound interest into a capital sum that can be withdrawn on retirement without attracting much tax. The plan is managed by a board of trustees initially appointed by the Council, and is meeting with well-deserved support.

Conclusion.

In conclusion, one may say that the future plans of the B.M.A. in Queensland are: to collaborate with and advise the State Government on all matters relating to the health of the people; to improve the skill, knowledge and efficiency of its members in their service to the public; to enhance their prestige in the community; to help them remain independent and financially secure; and generally to preserve the good relationship that exists today between the Association and the people of Queensland and between the Branch Council and the individual members.

THE WESTERN AUSTRALIAN BRANCH.

IN 1898 the population of the crown colony of Western Australia was 167,800, with 56,500 living in the city area. There were then 118 registered medical practitioners; 45 of these were in the metropolitan area, then defined by a 12-mile radius from the centre of the city of Perth, and the rest were distributed over the remainder of the State, which makes up one-third of the continent.

In that year two new arrivals in the Colony, Dr. Herbert Horrocks and Dr. Roberts Stewart, interested a number of doctors in the idea of forming a medical society, and an inaugural meeting was held on August 6 in the board room of the Perth Public Hospital. Thirteen practitioners were present. It was resolved to form a West Australian medical association, and a committee was appointed to study the procedure necessary to obtain permission from the British Medical Association in Great Britain to form a local Branch. The second meeting, held during the following month, saw the West Australian Medical Association well launched with the enrolment of 27 foundation members. At this meeting a set of rules and by-laws suggested by Dr. W. T. Hayward, the honorary secretary of the South Australian Branch, were adopted. At the third meeting Dr. W. T. Dermer and T. L. Anderson, of Fremantle, were present as visitors, and were empowered to state the willingness of the members of the Fremantle Medical Association to join the proposed Branch of the B.M.A. Although only 12 miles away, Fremantle was quite a separate community in those days of slow and difficult communication.

In March, 1899, a letter from the General Secretary of the B.M.A. in London was read, alterations to the by-laws suggested by him were made, and the Western Australian Branch of the B.M.A. came into being.

Medico-social activities began early. Three months after the Branch was founded a Parliamentary Bills Committee was elected, and was immediately concerned with "a necessary alteration in the Public Health Bill as regards the notification of infectious cases". Also before the turn of the century, the importance of contract practice matters is seen in the numerous letters from country practitioners, especially from the then populous goldfields, in the records of deputations to the Colonial Secretary and in the "warning advertisements" and suggested forms of contract. In 1899 the Branch was asked to advise the Government on by-laws dealing with shops, dairies and food supervision. (It appears that the Council, having been democratically elected, was entrusted completely to attend to all these and other matters, as there are only the briefest reports to general meetings, which are almost exclusively concerned with scientific and clinical activities.)

In 1900 the members became subscribers to the *Australasian Medical Gazette*, published in New South Wales. In the same year there is record of the expressed desire for a federation of all the Branches of the several separate colonies.

A plan for a medical defence union was considered in 1901, but this scheme lapsed. It was not until 1925 that such a union was successfully established, and it has continued with growing financial strength to serve the members from that time.

Throughout the early years there were many discussions about forming a medical benevolent fund, but this was not achieved until 1926. Contribution to this fund was voluntary until a general meeting in 1946, when the late Dr. Donald Smith spoke to his notice of motion: "That the Annual Subscription be increased by one guinea and this amount be transferred to the Medical Benevolent Fund." He considered that the small resources of the fund were no credit to a prosperous profession. His audience was not very sympathetic and favoured continuation of the voluntary principle. Donald Smith stood up and said: "Mr. President, it is now seven minutes to ten. I shall speak until 10 o'clock. You will then all be ashamed of yourselves and you will carry this motion unanimously!" And it was so.

In 1912 there is reference to a committee appointed to interview the Colonial Secretary and "ask if doctors driving their own motor cars could not be allowed a little more licence than ordinary drivers and to point out that the allowed rate of 12 miles per hour is absurd".

Early in 1914 members took up debentures in the recently formed Australasian Medical Publishing Company Limited which in that year began to issue THE MEDICAL JOURNAL OF AUSTRALIA.

It was at the instigation of the Branch, and through the force of its arguments directed to the Government, that in 1901 a sanatorium for the treatment of tuberculosis was established at Wooroloo in the hills outside Perth.

The beginning of what was to become a voluminous set of files on the *Workers' Compensation Act* was made in 1905, and the same year saw the first model common form of agreement drawn up for contracts with the friendly societies.

The Branch was incorporated and obtained its seal in 1911, and from this time on the records deal with those innumerable subjects which make up the year-by-year activity of all Branches.

The Branch library came into being in 1925, and grew rapidly under the scholarly guidance of the late Dr. Cyril Bryan, and later under the driving enthusiasm of the late Dr. Harry Lucraft. Over the years 1925 to 1956 the library travelled around the town. For a time it was housed in the Board Room of the Perth Public Hospital (now the Royal Perth Hospital) and later it was located on one of the upper floors of Chennell House at the western end of St. George's Terrace. In 1939, when the Branch obtained space on the ground floor of Shell House, accommodation was found for the library in the one large room which also served as a general office and Council room. The library was by now a comprehensive one, and the Branch was proud of it. It was an expensive adjunct to the Branch with its full-time librarian and, later, an assistant, and in the years following the second World War, two guineas of every subscription were allocated to it. In 1948 the library was moved once again back to the Royal Perth Hospital and given comfortable and spacious accommodation in a completely refurbished section of the old administration block of the hospital. However, it was destined to move again, for in 1956, to mark and to assist the establishment of the Medical School of the University of Western Australia, the Branch offered its whole library to the University for the new School, and today it is fused with the University medical library in the Medical Library of Western Australia, under the joint administration of the University and the B.M.A. The profession continues to contribute £1000 each year for the purchase of books and journals.

At the outset, the administrative work of the Branch was done by the honorary efforts of its members; but the work increased, and in 1915 Mr. Neilson Hancock was appointed part-time secretary, and he continued in that role until his retirement in 1944. He had been far more than a competent part-time secretary during this long period. In many ways he was the father of the Branch, and he was its one constant element in the long years of growth. He had worked prodigiously for small reward. On his retirement, Mr. Hancock's son Hugh took over the family business and the part-time work for the Association. However, it soon became clear that the rapid post-war growth of the community and the profession was demanding full-time management both for the Branch secretariat and for Mr. Hancock's own business. And so, in 1955, Mr. R. G. Hayward was appointed full-time Branch secretary, and the benefits of his industry and efficiency were soon obvious to all, especially to the office-bearers of Council, who were relieved of a great deal of detail work.

FIGURE I.
B.M.A. House (Western Australian Branch) in King's Park Road, Perth.

Until 1939 the Branch had no fixed headquarters. Its administrative nerve centres were Mr. Hancock's office and the consulting rooms of its office-bearers. For many years Council meetings were occasionally held in the Perth Hospital Board Room, but mostly in rotation in the homes of its members. Councillors of that time tell of the pleasant atmosphere of these meetings; but as the number of Council members grew from seven or eight to 14 or 15, this delightful arrangement became more and more difficult, and in 1939 a large room was rented on the ground floor of Shell House just along the passage from Mr. Hancock's office. This room served as Council room and general office and also housed the library for some years.

Over the past 25 years, a number of proposals were made for the purchase of a home for the Branch. Until very recently they were all deferred. So long as it was possible to "get by", there was a conservative reluctance to venture

the small reserves of the members' funds on a real estate investment. However, the rapid growth of the membership, the need for a full-time secretary and the belief that the owners of Shell House would be requiring the space occupied by the Branch, meant that a decision could be deferred no longer.

In 1954 the nettle was finally and firmly grasped, and an old two-storey residence was purchased in King's Park Road, close to the professional part of the city. The secretary and his staff took over the ground floor in 1955, and worked for three years in rather dilapidated con-

FIGURE II.
The Council Room.

ditions. A large living room served as Council room and general office. The upstairs space continued to be let as "bed-sitters", and it is probable that this is the only Branch which has conducted a lodging house.

Plans were soon afoot to erect a three-storey building on the space between the street and the old residence, and this was to provide professional suites and, later, accommodation for the Branch. Plans were well advanced, and arrangements made with future tenants, when it was discovered that the electricity supply of this old residential area would not be adequate for some years for the satisfactory functioning of lifts, X-ray machines, etc. Very regretfully, and at no little cost, Council had to postpone this project. Attention was then immediately given to altering the existing building, and this major operation was commenced. During the next eight months the building was re-roofed and completely "gutted", the western boundary wall moved 10 feet and the whole structure modernized. The skilful planning of the secretary and the cooperation of the architect and builder made it possible for the staff and Council to use the building throughout this period, although mostly under trying conditions. The building (Figure I) was officially opened by the senior past-President, Mr. F. A. Hadley, on Saturday, October 25, 1958, in the presence of the General Secretary of the Federal Council, Dr. John Hunter, the Editor of THE MEDICAL JOURNAL OF AUSTRALIA and some 300 members. It provides Branch office accommodation, a Council Room (Figure II), a flat for the housekeeper and five professional suites.

The work of the Branch now goes on in greater comfort and with greater efficiency. Its service to its members and to the community has improved, and a changing attitude—almost a new respect—is already noticeable in those sections of the lay public which have dealings with the Association. This dream of a home for the B.M.A. has been realized because many members have worked hard for it, and because many others have been generous with their money. Even so, it is doubtful whether the dream would have come true so soon, or so painlessly or with such happy results or with such economy, had it not been for the hard work, enthusiasm and organizing ability of the secretary, Mr. Hayward. The Branch acknowledges its debt.

The story of this Branch's long efforts to obtain a medical school and of the climactic deputation to the Premier in 1955, which at last brought the hoped-for decision, has been previously told in this Journal.

There remains only to report one final development within the Branch. On February 4 of this year, after two years of detailed preparation, there was launched the Medical and Allied Professions' Superannuation Plan of Western Australia. It provides for the self-employed members of the Branch a convenient and advantageous method of investing their savings for ultimate retirement from active practice. The Western Australian Branch acknowledges the assistance it has obtained from the Queensland Branch in the preparation of this scheme.

THE TASMANIAN BRANCH.

ALTHOUGH the history of medicine in Tasmania may be said to start from August, 1803, when Dr. Mountgarrat, surgeon, landed at Risdon Cove with the small party of soldiers and prisoners under the command of Lieutenant Bowen, the Tasmanian Branch of the British Medical Association was not founded until as late as 1911. For many years before the foundation of the Branch the Medical Section of the Royal Society of Tasmania had provided the opportunity for the doctors of the island to meet together and discuss the art and science of their profession, but there was no organization available to look after the material welfare or political interests of the medical men. There were a few members of the British Medical Association residing in the State, but their membership was attached to the Victorian Branch.

On July 2, 1911, Dr. Gregory Sprott convened a meeting, which was attended by nine members of the Association, who proceeded to form themselves into the Tasmanian Branch. Thirty new members were elected before the end of the year; and by the time of the second annual meeting there were 72 members out of a total of 113 medical practitioners registered and residing in the State.

The early records of the Branch reveal a prolonged, and sometimes bitter, struggle to improve conditions of medical practice, especially in connexion with contract practice and hospital services, but also a continued interest in the advancement of medical science.

In 1925, to meet the wishes of members residing in the northern part of the island, who found it difficult to attend meetings in Hobart, the Branch was reorganized as a Branch with two divisions, Northern and Southern.

At the present time regular divisional meetings are held in Hobart and Launceston, while the Branch Council acts as a coordinating and executive body for the whole State.

Because Tasmania is the smallest of the States, with a correspondingly small number of medical practitioners, financial difficulties have delayed the purchase of a building to serve as the headquarters of the Branch. A suitable building is now being acquired; but some further time must elapse before it can be fully adapted to the use for which it is intended.

Australasian Medical Publishing Company Limited

THE COMPANY, THE JOURNAL AND THE PRINTING HOUSE

ON PLAQUES at the foot of the stairway in the main entrance to The Printing House (Figure I) are commemorated the names of Robert Henry Todd, founder of the Australasian Medical Publishing Company Limited and of THE MEDICAL JOURNAL OF AUSTRALIA, William Henry Crago, first Chairman of Directors from 1913 to 1923, William Nathaniel Robertson, Chairman of Directors from 1923 to 1929, Thomas Walter Lipscomb, Chairman

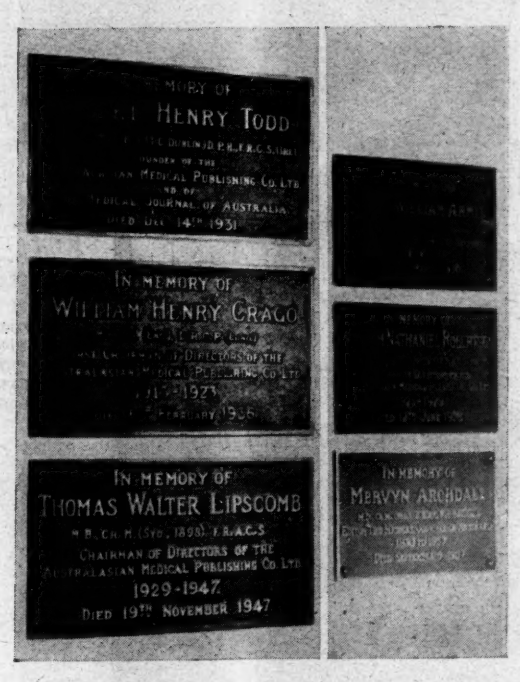

FIGURE I.
Plaques at The Printing House.

from 1929 to 1947, Henry William Armit, Editor from 1914 to 1930, and Mervyn Archdall, Editor from 1930 to 1957. Each of these men has left his mark on a road that helps to preserve for the future the results of research by Australian investigators in the medical and allied sciences.

The story of the Australasian Medical Publishing Company Limited and of THE MEDICAL JOURNAL OF AUSTRALIA began officially just under half a century ago, but the idea lying behind it goes back much further. In 1892, at the third session of the Intercolonial Medical Congress held at Sydney, a resolution was adopted that it was desirable to found an Australasian medical journal. The idea was again brought forward at the fourth session held at Dunedin in 1896. Three journals were concerned: the *Australasian Medical Gazette*, which belonged to the New South Wales Branch of the British Medical Association, and was the official organ of all the Branches of the Association in Australia except the Victorian; the *Intercolonial Medical Journal of Austra-*

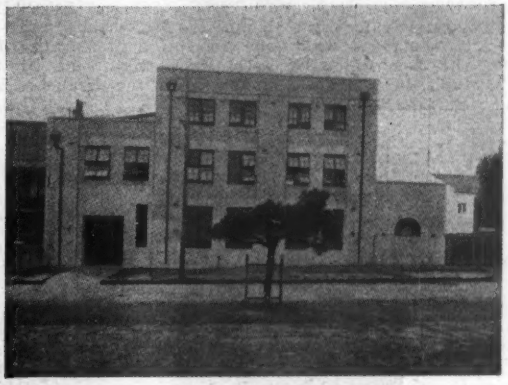

FIGURE II.
A view of The Printing House from Arundel Street in 1925.

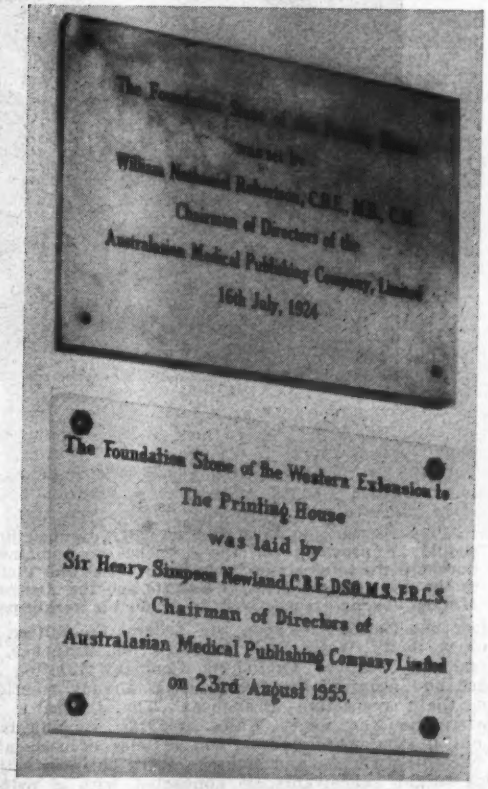

FIGURE III.
Foundation stones.

lasia, which was the official organ of the Victorian Branch; the *New Zealand Medical Journal*, which was owned by the New Zealand Branch. However, proposals to amalgamate the three journals met with insuperable opposition. Various expedients offered at the time to overcome the difficulties included the formation of an Australian Medical Association, and that proposal was again brought forward in 1902, only to be rejected once more. Apparently there was wide agreement that a single journal for the profession in Australia at least was desirable, but the Australian Branches, having no national unity, were unwilling to sacrifice their individuality in the matter of journals. It was not until the Federal Committee of the British Medical Association in Australia came into being that anything more of a positive nature was done in the matter. In May, 1911, the two following resolutions were sent by the newly formed Federal Committee to the Branches for their consideration and approval:

1. That in the opinion of this committee the branches of the British Medical Association in Australia should conjointly own and conduct one weekly paper.

2. That in the opinion of this committee the machinery should be provided for the branches to combine to purchase the interests of New South Wales and Victoria in the *Australasian Medical Gazette* and the *Australian Medical Journal*[1] respectively to conduct a weekly paper.

After negotiations between the Federal Committee and the New South Wales and the Victorian Branches, the Australasian Medical Publishing Company Limited was formed and acquired the two journals already mentioned from their respective Branches. The Company was registered in New South Wales in 1913. Its objects, as set out in the memorandum and articles of association, are exceedingly wide, and embrace every business activity which might conceivably be connected with a printing and publishing house, so that there are no reasonable limits to the activities in which it may engage. The constitution of the Company is simple. Each Branch of the British Medical Association in Australia has power to nominate three members of the Company. The directorate is composed of one member representing each of the six Branches, with the exception of New South Wales, which has two members of the Company as directors. The original directors were Dr. W. H. Crago (Chairman), Dr. W. Kent Hughes, Dr. W. N. Robertson, Dr. F. S. Hone, the Honourable Dr. A. Saw and Dr. Gregory Sprott. Soon after its establishment the Company issued debentures to members of the Branches of the British Medical Association in Australia, in order that money might be raised to defray the initial expenses. As the first stage of the development of THE MEDICAL JOURNAL OF AUSTRALIA, the directors sent a contract for the printing of the Journal to Shipping Newspapers Limited and engaged Dr. Henry William Armit as whole-time editor. He came to Australia with a strong recommendation from the then editor of the *British Medical Journal*, and within a month of his arrival in Sydney produced the first issue of THE MEDICAL JOURNAL OF AUSTRALIA, on July 4, 1914. Later Armit was made Manager as well as Editor, and most of the credit for the initial development of the Journal, despite the difficulties that occurred, must be given to this able and seemingly tireless man.

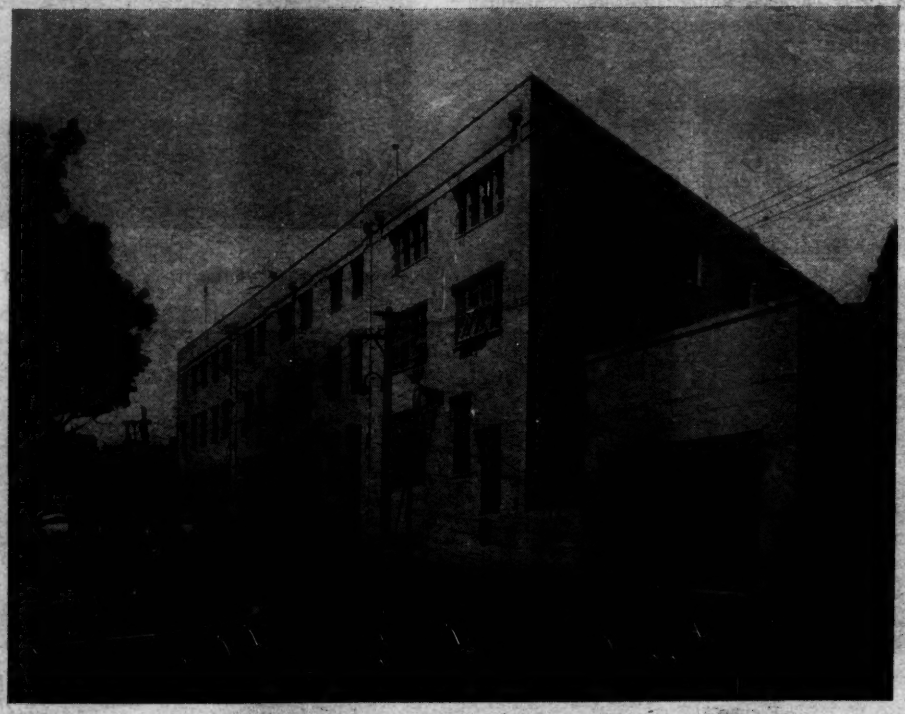

FIGURE IV.
A view of The Printing House in 1958 showing The Western Extension.

The second stage of the development came as a result of problems in printing and production during the latter years of the war and the immediate post-war period. As a solution to these difficulties it was decided to set up a typesetting and composing plant. This was installed on the fifth floor of the British Medical Association building in Elizabeth Street, and the Journal staff moved to that floor from its original offices on the first floor of the building. The entire staff then consisted of the Editor, the Assistant Editor, the Editor's secretary, a

[1] This was the official organ of the Victorian Branch, the name of the journal having been changed in 1910.

book-keeper, a linotype operator, a compositor and an apprentice. The first issue set up by the Company's plant was published on October 8, 1921. Originally the Assistant Editors were appointed on a part-time basis. The first was Dr. J. P. Hastings; he was followed by Dr. H. G. Chapman and then for a short period by Dr. A. W. Holmes à Court. In 1921, Dr. C. G. McDonald became the part-time Assistant Editor, to be succeeded

FIGURE V.
A section of the composing room with the battery of linotypes in the background.

for a few weeks by Dr. Keith Inglis and then in April, 1922, by Dr. Mervyn Archdall.

It was then proposed that the Company should extend its activities and acquire its own complete printing plant, so that it might produce not only THE MEDICAL JOURNAL OF AUSTRALIA, but other scientific periodicals and books. A firm of chartered accountants reported favourably on the scheme, and the directors

FIGURE VI.
The ground floor of The Western Extension showing the new quad-demy Miehle printing press, the folding machine and the gatherer-stitcher-trimmer.

finally decided that the Company should own its own premises. So began the third stage of development in the company. Money was raised by debentures, which were taken up by members of the B.M.A. in all six Australian Branches, and an allotment was made to each State, so that the financial interests of its members would be as widely distributed as possible; this policy has been maintained. The Company acquired an excellent piece of land in the highest part of Glebe, near the University of Sydney, and the foundation stone of The Printing House was laid on July 16, 1924, by Dr. W. N. Robertson, Chairman of Directors. Modern machinery and equipment were installed, a staff of skilled workers was engaged, and on March 21, 1925, the first Journal was published from the new building. In this issue the figure of Aesculapius appeared on the front cover of the Journal, where it has remained as a characteristic feature; it was copied from the Gold Medal of the British Medical Association in Australia. A full description of The Printing House at this time (Figure

FIGURE VII.
The first floor of The Western Extension with the proof-press in the centre, the reading rooms and the monotype keyboard room in the background.

II), and a much fuller account of the previous history than we have been able to give, will be found in the issue of the Journal of April 11, 1925.

Then began an important period of consolidation and slow growth. In August, 1929, the positions of Editor and Manager were again made separate, and Mr. Arthur Simpson was appointed Manager. Dr. Armit died in

FIGURE VIII.
The gatherer-stitcher-trimmer.

March, 1930, with the knowledge that he had given to the medical profession of Australia the scientific printing press at which he had aimed. He was succeeded by Dr. Mervyn Archdall, who continued the development of the Journal, maintaining its high scientific and literary level. As the Company grew, with an increase in the amount of work to be handled, new machinery was acquired, and by the end of 1934 the building had become too small. The Company was now in a sound position, and it was decided to extend the building. This was done, and in 1935 a triangular addition was made to the

building, bringing it right up to the corner of Seamer Street and Arundel Street. From then on the Company continued to grow, although its activities were inevitably slowed by the Second World War. The immediate post-war period brought its own difficulties and then began a period of further development and change. Mr. Simpson retired in 1948 from his position as Manager for reasons of health, and was succeeded by the present Manager. The present Editor was appointed on Dr. Archdall's retirement, shortly before his death in 1957.

The next major stage in development began when the foundation stone of The Western Extension to the Printing House (Figure III) was laid on August 23, 1955, by the Chairman of Directors, Sir Henry Newland, in the presence of a representative gathering of members of the profession and other distinguished visitors.

Figure IX.
A section of the main machine room.

The extension was completed early in 1957. It consists of three floors and a basement, all served by a lift, and it has added to The Printing House the extra floor space wanted for so many years. The basement is used for the storage of bulk paper, the ground floor as part of the machine room and the first floor as an addition to the composing room with rooms to accommodate the readers and monotype keyboard operators. The second floor is used for amenities, offices and the board room.

The completion of the extension brought to fruition a project that had been commenced about twenty years earlier, when the houses adjoining The Printing House were purchased by the Company, and when the late Dr. T. W. Lipscomb, after whom the board room was named, was Chairman of Directors. Unfortunately, at that time plans drawn up by the Company's architects for the extension had to be shelved because of the advent of the Second World War. The housing situation became so difficult that the Government passed legislation prohibiting the demolition of certain premises, and the Company was unable to obtain the necessary permission to demolish the houses adjoining The Printing House. Later the power situation in Sydney, an aftermath of the war, became acute, and the County of Cumberland Planning Scheme affected the Company's land at Glebe. It was declared to be in a residential area, and the Company lodged a claim for compensation for injurious affection for some two hundred thousand pounds. The power failure became very serious, and a generating plant was purchased and installed in a temporary position in the machine room.

Application was then made to the appropriate authority under the County of Cumberland Planning Scheme for permission to erect a small building to house the generating plant. Because of the special circumstances, this was granted, and the small building was erected and may be seen at the side of The Western Extension (Figure IV). In addition to housing the generating plant, the building is now used as a garage for the Company's motor truck.

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The Medical Journal of Australia

SATURDAY, MARCH 21, 1959.

THE MEETING OF THE COUNCIL OF THE WORLD MEDICAL ASSOCIATION.

NEXT Wednesday, March 25, 1959, the Council of the World Medical Association meets in Sydney under the chairmanship of Dr. L. Mallen, of Adelaide. The holding of this meeting here with one of our own Federal Councillors in the chair is an important event for Australia and Australian medicine. Our visitors may be assured of a warm welcome amongst us, and we hope that their coming will stimulate amongst Australian doctors the fullest response to the challenge of world medicine. Because of our geographical isolation it was almost inevitable that Australia should have been somewhat insular in its outlook in the past, but this situation has been changing greatly of recent years. Those living in Australia no longer feel themselves cut off to the same extent as they did from the great centres of cultural, scientific, commercial, political and other activity, and more and more Australians have been making their positive and distinctive contributions in world developments. Amongst the great international organizations the World Medical Association has made remarkable progress in the twelve years since it came into existence, and it must now be regarded as a significant factor in world affairs. Its aims and principles are in close harmony with the outlook of the medical profession in Australia and are exerting an increasing appeal in this country. That appeal will be greatly strengthened by the fact that the Council of the World Medical Association has seen fit to make the rather long journey to Sydney to meet, and it is to be hoped that before very long it will be practicable to have the General Assembly meeting in this country.

This special issue of THE MEDICAL JOURNAL OF AUSTRALIA has been produced as a compliment to our visitors and as a means of informing them about the activity of the organized medical profession in this country in so far as it is represented by the British Medical Association. No attempt has been made to refer to special bodies such as the Colleges, although the importance of their contribution to Australian medicine is fully acknowledged. It is hoped that the broad picture presented will be acceptable to medical practitioners and others throughout Australia as well as to our guests.

THE BRITISH MEDICAL ASSOCIATION IN AUSTRALIA.

FOR the information of our visitors and to refresh the memories of our regular readers, the opportunity has been taken in this special issue to present the picture of the British Medical Association in Australia. For the articles on the several Branches and on the Federal Council we are indebted to the Branches concerned, and to Dr. John Hunter, General Secretary of the Federal Council, who was responsible also for the article on "Health Care in Australia". To collect these separate accounts together some further comment may be helpful.

In each of the six States of Australia is a Branch of the British Medical Association. These Branches were formed separately and are separate parts of the Parent Body in England. They adhere to its two objects—to promote the medical and allied sciences, and to maintain the honour and interests of the medical profession; and they have its status, that of a private or voluntary organization without statutory powers. Each Branch has two representatives on the Council of the Association, which meets in London; it sends delegates to the Annual Representative Body, which represents the parliament of the Association; and it is represented at the Annual Meeting, which may be held in any part of the constituent areas. Every member of the Association in Australia receives the *British Medical Journal* by virtue of his membership (as he also receives THE MEDICAL JOURNAL OF AUSTRALIA), and certain overseas membership payments are made to London in respect of Australian members. At the same time the Australian Branches have a great deal of autonomy and control their own actions.

On the question of when the Australian Branches were formed there has been a little confusion. Although there was considerable activity in getting Branches under way in South Australia and in Victoria at least in 1879, and this with the warm approval of the Parent Body, it is clear that none of the Branches in Australia was recognized officially until 1880. Reports of the meetings of the Committee of Council of the B.M.A. in London published in the *British Medical Journal* show that the "Branch for Adelaide and South Australia" and the "Branch for Sydney and New South Wales" were recognized on July 7, 1880,[1] and the "Branch for Melbourne and Victoria" was recognized on August 10, 1880.[2] The Queensland Branch was officially recognized in 1894, the Western Australian Branch in 1898, and the Tasmanian Branch in 1911. From small beginnings the six Branches have grown steadily. The New South Wales Branch with a present membership of over 4000 is the largest. The Victorian Branch comes next with a membership of nearly 3000. The total Australian membership is over 10,000 and includes the great majority of medical practitioners in Australia.

After the federation of the Australian States on January 1, 1901, people were beginning to think federally, and the members of the medical profession were no exception. From South Australia came the suggestion that a Federal Committee of the British Medical

[1] *Brit. med. J.*, July 17, 1880.
[2] *Ibid.*, September 4, 1880.

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THE MEETING OF THE COUNCIL OF THE WORLD MEDICAL ASSOCIATION.

NEXT Wednesday, March 25, 1959, the Council of the World Medical Association meets in Sydney under the chairmanship of Dr. L. Mallen, of Adelaide. The holding of this meeting here with one of our own Federal Councillors in the chair is an important event for Australia and Australian medicine. Our visitors may be assured of a warm welcome amongst us, and we hope that their coming will stimulate amongst Australian doctors the fullest response to the challenge of world medicine. Because of our geographical isolation it was almost inevitable that Australia should have been somewhat insular in its outlook in the past, but this situation has been changing greatly of recent years. Those living in Australia no longer feel themselves cut off to the same extent as they did from the great centres of cultural, scientific, commercial, political and other activity, and more and more Australians have been making their positive and distinctive contributions in world developments. Amongst the great international organizations the World Medical Association has made remarkable progress in the twelve years since it came into existence, and it must now be regarded as a significant factor in world affairs. Its aims and principles are in close harmony with the outlook of the medical profession in Australia and are exerting an increasing appeal in this country. That appeal will be greatly strengthened by the fact that the Council of the World Medical Association has seen fit to make the rather long journey to Sydney to meet, and it is to be hoped that before very long it will be practicable to have the General Assembly meeting in this country.

This special issue of THE MEDICAL JOURNAL OF AUSTRALIA has been produced as a compliment to our visitors and as a means of informing them about the activity of the organized medical profession in this country in so far as it is represented by the British Medical Association. No attempt has been made to refer to special bodies such as the Colleges, although the importance of their contribution to Australian medicine is fully acknowledged. It is hoped that the broad picture presented will be acceptable to medical practitioners and others throughout Australia as well as to our guests.

THE BRITISH MEDICAL ASSOCIATION IN AUSTRALIA.

FOR the information of our visitors and to refresh the memories of our regular readers, the opportunity has been taken in this special issue to present the picture of the British Medical Association in Australia. For the articles on the several Branches and on the Federal Council we are indebted to the Branches concerned, and to Dr. John Hunter, General Secretary of the Federal Council, who was responsible also for the article on "Health Care in Australia". To collect these separate accounts together some further comment may be helpful.

In each of the six States of Australia is a Branch of the British Medical Association. These Branches were formed separately and are separate parts of the Parent Body in England. They adhere to its two objects—to promote the medical and allied sciences, and to maintain the honour and interests of the medical profession; and they have its status, that of a private or voluntary organization without statutory powers. Each Branch has two representatives on the Council of the Association, which meets in London; it sends delegates to the Annual Representative Body, which represents the parliament of the Association; and it is represented at the Annual Meeting, which may be held in any part of the constituent areas. Every member of the Association in Australia receives the *British Medical Journal* by virtue of his membership (as he also receives THE MEDICAL JOURNAL OF AUSTRALIA), and certain overseas membership payments are made to London in respect of Australian members. At the same time the Australian Branches have a great deal of autonomy and control their own actions.

On the question of when the Australian Branches were formed there has been a little confusion. Although there was considerable activity in getting Branches under way in South Australia and in Victoria at least in 1879, and this with the warm approval of the Parent Body, it is clear that none of the Branches in Australia was recognized officially until 1880. Reports of the meetings of the Committee of Council of the B.M.A. in London published in the *British Medical Journal* show that the "Branch for Adelaide and South Australia" and the "Branch for Sydney and New South Wales" were recognized on July 7, 1880,[1] and the "Branch for Melbourne and Victoria" was recognized on August 10, 1880.[2] The Queensland Branch was officially recognized in 1894, the Western Australian Branch in 1898, and the Tasmanian Branch in 1911. From small beginnings the six Branches have grown steadily. The New South Wales Branch with a present membership of over 4000 is the largest. The Victorian Branch comes next with a membership of nearly 3000. The total Australian membership is over 10,000 and includes the great majority of medical practitioners in Australia.

After the federation of the Australian States on January 1, 1901, people were beginning to think federally, and the members of the medical profession were no exception. From South Australia came the suggestion that a Federal Committee of the British Medical

[1] *Brit. med. J.*, July 17, 1880.
[2] *Ibid.*, September 4, 1880.

Association should be formed in Australia. After some preliminary discussions the Branches agreed to this suggestion, and the first meeting of the Federal Committee was held at Melbourne in May, 1912, under the chairmanship of the late William Thornborough Hayward, of Adelaide. The objects of the Federal Committee were twofold. The first was the formation of an advisory body to discuss with the Branches matters affecting Australia as a whole; the second was the establishment of one medical journal for the whole Commonwealth. The first object was carried out with increasing success, and through the action of the Federal Committee there was brought into being the Australasian Medical Publishing Company Limited, which established THE MEDICAL JOURNAL OF AUSTRALIA, the first issue appearing on July 4, 1914. After some years it was clear that the time had come for an extension of the work of the Federal Committee, that it might become more of an executive and less of an advisory body. Preliminary discussions took place with the Parent Body in England on the powers that should be granted to overseas Branches. The Australian Branches, while anxious to retain the link with the Old Country, wished to govern themselves. The process by which matters of even small moment had to be referred to the Council of the Parent Body in England for approval was time-consuming and irksome. After agreement had been reached on these points, the Federal Committee changed its name and became the Federal Council of the British Medical Association in Australia. The Federal Council became an incorporated body on May 15, 1933.

It is as well to emphasize that, apart from very necessary medico-political activity, the Branches and the Federal Council devote much attention to the advancement of medical science and to the encouragement of a high standard of professional ability and practice in the members of the Association. The triennial Australasian Medical Congress, which is a Federal Council responsibility, is of great importance in this regard. The Federal Council is also represented on the National Health and Medical Research Council, and its present representative is chairman of the Research Committee of that council. The Branches nominate representatives to a great many organizations, in order that the medical scientific field may be adequately represented, especially in non-medical contexts where it is important. Similarly, the fullest cooperation is offered to the non-medical Press with the object of having medical news and comments presented to the public accurately and reasonably. Within the Branches regular scientific meetings are held, at which papers are read and clinical demonstrations are presented. Of particular importance are the special sections of members concerned with special branches of medical science. Some of these sections are special groups working under the approval of the Federal Council; others function as State bodies run under the ægis of the Branches. Those with an Australia-wide membership are as follows: the Australian Society of Allergists (B.M.A.), the Australian Society of Anæsthetists (B.M.A.), the Special Group on Aviation Medicine (B.M.A.), the Dermatological Association of Australia (B.M.A.), the Ophthalmological Society of Australia (B.M.A.), the Oto-Laryngological Society of Australia (B.M.A.), the Australian Association of Physical Medicine and Rehabilitation (B.M.A.), the Australian Rheumatism Association (B.M.A.).

What of the future? There is a growing body of opinion in Australia that the medical profession should have its own national medical association, affiliated with the British Medical Association in the same way as are the corresponding bodies in Canada and South Africa. There is much to be said for this. To a great many medical men, of course, the idea implies the breaking of a vital link, and, as such, is in their view to be resisted. This view is not necessarily correct, and the practical position could indeed be exactly opposite to this. The grown-up son with sincere affection for his parents is more likely to retain that affection as a healthy attitude when he is free to live his own life than if he remains, no matter with how much freedom, under the parental roof. Moreover, essential changes are taking place: Australia as a nation is going her own way, and Australian medicine must be related to our own community and its developments; the Australian community is changing, and many of its newer members who are offering their fullest loyalty to the country of their adoption do not know (and it is no fault in them) the traditional tie with Britain that for many others is virtually inherent. Not least, Australia is finding a new and exciting destiny to work out in relation to her reawakened neighbours in Asia, and in this too Australian medicine must seek its rightful place. Our British heritage is of incalculable value and must by all means be preserved as part of our national possession. The essential question to be decided is whether this will be helped or hindered by our acceptance of the fact that we have grown up.

Current Comment.

CRYPTOCOCCOSIS.

A REPORT of nine cases of cryptococcosis (torulosis) from South Australia by L. L. Wilson[1] is a reminder that this disease is being diagnosed with increasing frequency, no doubt as a result of improved methods of diagnosis and an increasing awareness of the possibility of its occurrence. It is probable that in the past it has sometimes been confused with tuberculous meningitis. Wilson states that in Australia cryptococcosis has been reported on relatively few occasions. In fact, however, relative to the size of the population, it has been reported in Australia with a greater frequency than in most other parts of the world. This was pointed out by L. B. Cox and Jean C. Tolhurst[2] as early as 1946. The true incidence of the disease is perhaps better indicated by their statement that at the Alfred Hospital, in the period under review, 12 cases of cryptococcosis were confirmed, as against 35 of tuberculous meningitis and only two of hydatid disease of the brain. Since then at least 34 further cases have been reported in the Australian literature. The longest series is that of B. Geany, W. R. Horsfall and G. Neilson,[3] who reported 14 cases from Queensland collected over a period of six years. They raise the question as to whether this disease may not be relatively more prevalent among Australian aborigines, as four of their patients were

[1] *Aust. Ann. Med.*, 1958, 7: 276 (November).
[2] "Human Torulosis", 1946, Melbourne University Press.
[3] MED. J. AUST., 1956, 2: 378 (September 8).

aborigines, and they refer to three others. An alternative explanation would be that infection is more likely to be acquired in hot countries; in that case one would have to assume that the relative paucity of reports from tropical countries was due to the lack of diagnostic facilities. The causative organism, *Cryptococcus neoformans*, is stated to be very widely distributed, though only some strains are pathogenic. However, as with a number of other occasional pathogens, it is difficult to understand what are the conditions which in rare instances lead to the invasion of human tissues by such organisms. It is possible that this may be favoured by certain climatic conditions. It is by no means clear what is the usual portal of entry, though there are some grounds for supposing that in a considerable proportion of cases entry is through the lungs, with subsequent spread to the meninges and to other organs. Three main forms of the disease are recognized—the meningeal, which up to very recently has been invariably fatal, the pulmonary, and the generalized form with a long history of lymphadenopathy. Isolated pulmonary lesions can be cured by resection, and quite a number of cases have now been reported, including one of Wilson's series, in which patients so treated have survived in good health for many years after the operation. Two unusual cases are recorded in recent Australian reports, one by I. McConchie[1] and one by M. P. Susman,[2] in each of which pulmonary resection was performed in spite of evidence of meningeal involvement; in both cases the patient made a good recovery post-operatively. In McConchie's case the meningeal symptoms disappeared, and the organisms could no longer be found in the cerebro-spinal fluid; in Susman's case the patient was well and at work 11 months after pneumonectomy, but the organism could still be recovered from some specimens of cerebro-spinal fluid. It would be interesting to know the subsequent history of these two patients.

Cases in which there is a long history of lymphadenopathy include those in which there is an association with Hodgkin's disease. This is a very obscure aspect of cryptococcosis, which is discussed by Geany *et alii*, among others, and it is not clear to what extent this association is due to the ability of cryptococcosis under certain circumstances to mimic Hodgkin's disease, or to what extent it is due to a tendency for malignant change to supervene in the very chronic cases of cryptococcal infection, or whether the patients with Hodgkin's disease are simply more liable to granulomatous infections. C. Fortune *et alii*[3] refer to reports of an association between cryptococcosis and myeloid leukæmia, but we are not aware that any such cases have been reported in Australia.

Apart from the likelihood that with improved methods of diagnosis the condition is likely to be found with increasing frequency, the subject of cryptococcosis is topical because of encouraging reports that an effective antibiotic against *C. neoformans* is at last available in the shape of amphotericin B ("Fungizone"). In spite of early encouraging reports, experience with its predecessor "Actidione" was generally disappointing, and reports of the use of that drug in cases of cryptococcal meningitis mostly end with an account of the findings at autopsy. Amphotericin B is an antibiotic isolated from a species of *Streptomyces*, and several reports of its successful use in cases of cryptococcal meningitis have been published in American journals. A recent paper by J. H. Seabury and H. E. Dascomb[4] describes their experiences with it in the treatment of various systemic mycoses. They state that amphotericin B has no antibacterial action, but is very effective *in vitro* against those yeast-like fungi which cause deep mycotic infection in man. One of the difficulties in its application is that in its crystalline form it is highly insoluble, and in their earlier cases it was used in suspension. However, since the end of 1956 a more convenient preparation has been available which has the gross characteristics of a solution when reconstituted in water, though it is actually a colloidal suspension. Seabury and Dascomb found amphotericin B ineffective when given by mouth or by intramuscular injection, but efficient when given intravenously or intrathecally. They state that the systemic side effects are mild or moderate, though these appear alarming enough. All but one of eighteen patients developed rigors and moderate fever during the first few infusions (in 500 ml. of 5% dextrose solution) of the drug, but this reaction diminishes with continued treatment. Other reactions include anorexia, abdominal pain, nitrogen retention and, in one case, melæna. However, they found amphotericin B highly effective in cases of histoplasmosis and blastomycosis. They treated seven patients suffering from cryptococcal meningitis with it, and obtained a good response in five. One patient was admitted to hospital in a comatose condition and died soon after treatment was begun, and one refused parenteral therapy. Three others remained well and active for periods up to 12 months after the cessation of therapy, one patient was still under observation, and treatment was suspended prematurely in the case of a boy aged 15 years because of recurrent azotæmia. Seabury and Dascomb also used amphotericin B in cases of coccidioidomycosis, sporotrichosis and systemic candidiasis, but the number of cases treated was too small to evaluate the drug in these conditions. Parenthetically, it is interesting to note their statement that cryptococcosis is one of the commoner deep mycoses in Louisiana, though no doubt this should be qualified by the reservation that all are rare. They state that intrathecal administration by the method they describe is well tolerated, but they do not recommend this procedure more often than twice a week, as paræsthesiæ frequently appear after such injections. Intravenous infusions of the drug are given daily, or on every second day, as amphotericin B disappears slowly from the circulation.

In Wilson's series amphotericin B was used in two cases, but both ended fatally, though in one an initial improvement was halted when supplies of the drug became exhausted; treatment was resumed later, but the patient failed to respond. Wilson points out that many cases of cryptococcosis are diagnosed only when the organisms are found in the cerebro-spinal fluid, and that some serological method which would enable an earlier diagnosis to be made would greatly increase the chances of cure. It is therefore very satisfactory to note that a complement-fixation test for the diagnosis of cryptococcal infection has now been described by Kevin Anderson and Margaret Beech[1] from the Institute of Medical and Veterinary Science, Adelaide. It seems reasonable to conclude that, in spite of its somewhat alarming and occasionally serious side-effects, and in spite of some reports of sudden unexplained death during treatment, amphotericin B does offer a very real hope in the treatment of a condition which is otherwise almost invariably fatal.

[1] MED. J. AUST., 1951, 2: 685 (November 17).
[2] *Aust. N.Z. J. Surg.*, 1954, 23: 296 (May).
[3] MED. J. AUST., 1955, 2: 199 (August 5).
[4] *A.M.A. Arch. intern. Med.*, 1958, 102: 960 (December).

NEONATAL CANDIDIASIS (MONILIASIS).[5]

IT is probably fair to say that neonatal thrush is too often regarded with an indifference born of familiarity and the belief that it is a minor complaint which can be cured by a few applications of gentian violet. However, from time to time we are reminded that it is a potentially dangerous condition. To quote but one

[1] MED. J. AUST., 1958, 2: 601 (November 1).

[5] Infections by *Candida albicans* are still often referred to as cases of moniliasis, on account of the former incorrect use of *Monilia* as the generic name of this fungus. In the Medical Research Council's Memorandum, number 23, "Nomenclature of Fungi Pathogenic to Man and Animals" (revised edition, 1958), candidiasis is given as the correct name for such infections, with a note that "the Committee was not unanimous in recommending the use of Candidiasis in place of Moniliasis", the name moniliasis being therefore retained as a synonym.

example, in a recent paper, J. M. Wagner and I. Kessel[1] describe four cases of thrush œsophagitis, two of which ended fatally, in infants who had been healthy at birth, and cite numerous references to show that this condition is "a reasonably common disease" and carries a high mortality rate. They also mention the two other main serious complications of infection with *Candida albicans*, namely, broncho-pulmonary candidiasis and systemic candidiasis, both rare but extremely dangerous conditions. We now have an interesting and informative report from a group of doctors, L. J. Harris *et alii*, at the Mount Sinai Hospital, Toronto, who have studied the incidence of neonatal thrush in a large maternity hospital, and the means of preventing it.[2] They begin by pointing out that "it is a general misconception that thrush of the newborn is a completely benign disease, and that its incidence is so low and complications are so few that prophylaxis is not worthwhile", and go on to state that in their opinion thrush is an important nursery problem, and its prophylaxis a matter deserving serious attention. They cite reports to show that it has been found in nearly 20% of neonates in some small series, but believe that their own experience of about 4% in untreated infants is probably more usual. Previous investigations had agreed that the most likely source of infection was the mother's vagina, so they set out to determine the incidence of vaginal candidiasis among pregnant women at the onset of labour, as well as the subsequent incidence of thrush among their infants. In a consecutive series of over 1400 cases, it was found that 17·6% of the women harboured *C. albicans* in the vagina when admitted to hospital. Interesting incidental findings were that this incidence appeared to have little or no relationship to whether or not the patients had previously received courses of antibiotics for other conditions, and no relationship to whether or not the patient gave a history of douching; of the entire group, 53% gave a history of vaginal discharge, but nearly a third of those harbouring *C. albicans* gave no such history. As to the relationship between vaginal infection and neonatal infection, the lesson was clear. *C. albicans* was recovered in about 20% of cases from oral swabs from infants of the 254 mothers from whom vaginal cultures of *C. albicans* had been obtained; among the babies of the 1198 mothers whose vaginal cultures had failed to grow *C. albicans*, only 12 (1%) yielded *C. albicans* from oral swabs.

The second and more important part of the Toronto investigation was the experiment in prophylaxis. Every second infant had 1 ml. of a nystatin solution (containing 100,000 units) instilled into his mouth daily while in hospital. The result was a sweeping victory for prophylaxis. Of the 714 infants so treated not one developed oral thrush while in hospital, and only three developed it after going home (they were usually discharged from hospital on the fifth or sixth day); no demonstrable toxic or other effects were noted. Of the 728 infants who received no prophylaxis, 18 developed oral thrush while in hospital, and 13 more developed it during the week after they had gone home. In an addendum to their paper, the Toronto group state that they have since treated 650 infants with only two doses of nystatin, one on the second and one on the fifth day of life, and that not one of these developed thrush. They emphasize that the nystatin solution must be shaken thoroughly before it is administered, as it is only slightly soluble.

Among the other points which emerged from this study, it is interesting to note that the incidence of oral thrush was as high among bottle-fed as among breast-fed babies, indicating that contamination of the mother's nipples was not important as a means of infecting the infant. Figures relating to the effect of prematurity were too small to be significant, but seven of the 34 infants who developed oral thrush were premature, as compared with an incidence of prematurity of 5% in the group as a whole, thus strongly suggesting that prematurity predisposed to infection.

While one might hesitate to agree with the authors of this study that the elimination of thrush "would be almost as great a boon as was the elimination of gonorrhœal ophthalmitis by the prophylaxis of the eyes of the new born", they have certainly made out a good case for the very simple prophylactic measure which they suggest, and it will be interesting to see whether it becomes widely adopted. Their study has also gone a long way towards putting the facts about neonatal thrush and its relationship to vaginal thrush on a sound statistical basis.

[1] *Brit. med. J.*, 1958, 2: 362 (August 9).
[2] *Canad. med. Ass. J.*, 1958, 79: 891 (December 1).

THE SUDAN MEDICAL SERVICE.

WHENEVER the Anglo-Egyptian Sudan is mentioned it brings back schoolboy memories of a heroic figure in the person of General Gordon, and of that modest Australian contingent which set out from Sydney in 1885 to help the British forces subdue a formidable native uprising which had assumed a serious aspect with the unexpected siege of Khartoum. At the end of the century Lord Kitchener reconquered the Sudan with the help of Egyptian forces, and when he became Governor-General in 1899 Britain began a fresh effort to colonize that part of the Nile valley which commanded the water and so the wealth of all Egypt.

An important factor in the successful colonization of this vast area was the establishment in 1904 of a Sudan Medical Service, and its gradual development in scope and effectiveness over the first half of this century can be regarded in the light of a notable experiment in social medicine. How the serious problems—inadequate medical staff, the stringency of government financial assistance, the primitive notions of sanitation persistently adhered to by the superstitious native population, and constant threats to the community from the prevalent infectious diseases—were all faced and eventually overcome has been graphically recorded by H. C. Squires in a small book which should serve as a reliable guide to all future promoters of similar undertakings in any of the underdeveloped countries of the world.[1]

For nearly half a century, Squires has taken an active, leading and influential part in the organization and implementation of ambitious schemes to improve health conditions in the Sudan. In a few places he gives meticulous details about the local scene and the numerous personalities who have had some share in bringing these plans to fruition. Although such full details are necessary for recording purposes, they may fail to capture the interest of many outsiders. However, the information given regarding the ceaseless efforts of leading British officials, the heads of medical departments and their loyal staff of British, Egyptian and Syrian doctors to bring some sort of order out of chaos must surely arouse feelings of wonder and admiration in most readers.

In spite of the debilitating climate and a lack of the ordinary comforts and amenities of life, in the larger centres as well as in far distant outposts, the Sudan Medical Service effected many notable improvements in the provision of expert medical care for the inhabitants and in protecting them from disease. A special women's hospital was opened at Omdurman in 1925 with a training school for native nurses and midwives attached to it. Three years later the Kitchener School of Medicine was built in Khartoum, and from its inception a high standard of education and training was demanded as one of the main objectives. To illustrate what could be accomplished in the way of producing a competent Sudanese doctor, the career of Dr. Ali Bedri may be cited as an outstanding example. He qualified from the Kitchener School of Medicine in the first batch of students, then spent four years in hospital practice before going to London for post-graduate study at

[1] "The Sudan Medical Service: An Experiment in Social Medicine", by H. C. Squires, C.M.G., D.M., F.R.C.P., D.P.H.; 1958. London: William Heinemann (Medical Books), Limited. 8½" × 5½", pp. 150, with seven illustrations. Price: 15s. (English).

Hammersmith. There he obtained the diploma of membership of the Royal College of Physicians and was elected a Fellow of the College in 1952. He was the first Minister of Health to be appointed by the Sudan Government after the political situation changed in 1951. Several clear pictures of the medical institutions in the capital city are in themselves ample evidence of the successful efforts of the British to bring health, social welfare and the most modern medical and specialist services to what was not so long ago one of the underdeveloped countries of the world.

HYDROCEPHALUS.

IT is rather curious that the natural history of chronic diseases was for so long a neglected branch of medicine, since its study required no specialized techniques but merely accurate diagnosis and the careful collation of an adequate number of case histories. That it is still true that our knowledge of the natural course of some quite common conditions is very inadequate is emphasized by the recent publication of a paper on the natural history of hydrocephalus by K. M. Laurence.[1] Few would quarrel with his remark that "it is generally believed that few children with hydrocephalus survive, and that those who do are doomed to permanent institutional care". It is therefore something of a surprise to find not only that this is not so, but that no adequate study of the natural evolution of this condition appears to have been previously published. The opportunity to make this study arose because Mr. Wylie McKissock, working at the Atkinson Morley Hospital and at Great Ormond Street, remained unconvinced as to the merits of any form of surgery in these cases, and so a large number of patients with hydrocephalus attending these hospitals were left unscathed at a time when, at other centres, a determined search was in progress for a means of providing surgical relief for the condition—a search no doubt coloured in many cases by the belief that the victims were otherwise inevitably doomed to an early death. There is now a considerable literature on the progress of this search, and some remarkable results have been achieved with the establishment of drainage along curious routes through lengths of polythene tubing. In the assessment of the value of these techniques it is of fundamental importance to have a clear picture of the natural history of the condition in untreated cases.

Laurence studied 182 cases of hydrocephalus seen by McKissock between January, 1938, and December, 1957, in which no surgical interference was attempted. The series is considered as representative and unselected. The causes of hydrocephalus in these cases were classified as follows: malformation, 43; "trauma", 59; infection, 42; tumour, 4; unknown, 34. In most the hydrocephalus was acquired either through infection or through perinatal trauma or anoxia. Laurence considers it likely that those cases with insidious onset in which there was no history to suggest a cause were probably due to missed mild meningitis or perinatal injury. The four cases in which the hydrocephalus was caused by a tumour were diagnosed at autopsy, having been previously considered as of congenital origin.

It was possible to trace the subsequent history of all but three of these children. Eighty-nine had died, mostly in the first 18 months of life; 81 (46%) were alive, with the hydrocephalus arrested; in nine the condition was still progressive; three were untraced, but there was evidence that they were probably still alive. In most of those in whom arrest took place, this occurred between the ages of nine months and two years, but in a number arrest took place at ages between three and nine years.

Assessment of intelligence was obtained in all the 81 children with arrested hydrocephalus; 33 of these were of normal intelligence (I.Q. > 85), 26 were below normal, but were educable, and 22 were ineducable, with an I.Q. of less than 50. Many of the surviving children had severe physical handicaps, but 27 of those with arrested hydrocephalus had very little or no physical disability. It was noted that these children were not always those with the less severe head enlargement or thinning of the cortex. Similarly in 37 cases in which reliable information was availabe on the thickness of the pallium, it was found that this was not related to intelligence. There was a high correlation between intelligence quotient and the degree of physical handicap, those with least handicap making the higher scores.

It is not altogether a cheerful picture, but on the other hand neither is it one of such unrelieved gloom as most would probably have supposed.

[1] *Lancet*, 1958, 2:1152 (November 29).

RADIATION DOSES TO THE GONADS.

EFFORTS have been made in a number of countries to assess the radiation being fed to the gene material of the population from the diagnostic use of X rays, and a recent supplement to *Acta Radiologica* reports an extensive investigation on these lines carried out in Sweden by Lars-Eric Larsson.[1] Great care has been taken with the investigation, and the apparatus used and its calibration, together with the measurement methods adopted, are detailed. The ionization chambers used were placed, during examinations, on the scrotum in males and in the rectum or vaginal fornix in the female, the position chosen being dependent on the nature of the examination. Extensive information is given on various types of examinations carried out on adults and a smaller number on children. It is evident that there are wide variations between the different results, and some investigation has been made of the source of these variations. For example, it was found that the output of the tubes used on a screening stand varied by a factor of 14 between the highest and lowest found in a survey of a number of departments. Again, the personal factor enters into the situation; the variations brought about by differences in screening technique are demonstrated, and it is shown, particularly in examinations of male subjects such as those of the lumbar and sacral parts of the spine, pelvis, hips and so on, that variations in field size can alter the gonad dose by factors as high as 100. Larsson states that the personal factor which enters into this situation is affected chiefly by training, experience and proficiency; the importance of the first of these factors should certainly be stressed. Larsson has surveyed the attendance at a number of large hospitals to determine the distribution of various types of examination, and a table presenting these gives also the percentage of normal findings as a result of the examination. It is worth noting that the highest percentage occurs in obstetrics and pelvimetry examinations, and it is suggested that, particularly in these cases, more stringent indications for X-ray examination could be called for. Finally Larsson assesses the possible level of significant gonad dose at 72 mr. per head of population and suggests means by which it could be reduced, he estimates, to 28 mr.

All surveys of this type are open to criticism on the grounds that sampling does not give an adequate indication of the real situation. Larsson estimates the over-all accuracy of his result at $\pm$ 25%, which is probably the best that can be achieved. Further, in recent years the wide publicity which this hazard has received undoubtedly has resulted in a tightening up of X-ray diagnostic procedures in relation to gonad dose, with the result that measurements made now tend to give a point on a curve of descending values. We are unlikely, therefore, to know the level of exposure as it was a few years ago, and it would probably be valuable to make a similar survey in three to five years' time, when the various recommendations will have been implemented, to see how far down the level has been brought.

[1] "Radiation Doses to the Gonads of Patients in Swedish Roentgen Diagnostics: Studies on Magnitude and Variation of the Gonad Doses together with Dose Reducing Measures", *Acta radiologica*, Supplement 157, by Lars-Eric Larsson; 1958. Stockholm: Acta Radiologica. 9½" × 7", pp. 27, with 32 illustrations and 58 tables. Price: Sw. Kr. 30.

Abstracts from Medical Literature.

NEUROLOGY AND PSYCHIATRY.

Respiratory Abnormalities in Poliomyelitis.

F. PLUM AND A. G. SWANSON (*A.M.A. Arch. Neurol. Psychiat.*, September, 1958) discuss abnormalities in central regulation of respiration in acute and convalescent poliomyelitis. They point out that the clinical differences between the respiratory disturbances resulting from spinal cord involvement and the breathing defects produced by brain stem lesions have been recognized in poliomyelitis for over 50 years. They find that central respiratory failure in acute poliomyelitis evolves through three stages: first, respiratory rhythm is impaired during sleep. Then a dysrhythmic breathing persists into wakefulness, and conscious drives must be recruited to maintain respiratory regularity and compensation; impaired chemosensitivity to carbon dioxide is indicated by depression of ventilation while the patient is breathing oxygen. Finally, the respiratory response to chemical as well as to reflex and other neural stimuli shows progressive impairment and artificial respiration is required to maintain respiratory homoeostasis. The authors state that depressant drugs accelerate markedly the deterioration of central respiratory control in acute poliomyelitis. Pathological studies in two of their cases showed marked inflammatory changes and small areas of necrosis in the ventro-lateral reticular formation of the medulla. Irregular respiration during sleep persisted in two of the patients for many months after acute poliomyelitis. These patients demonstrated carbon dioxide retention without dyspnœa, an impaired ventilatory response to increased tensions of inspired carbon dioxide, and reduction in ventilation while breathing 100% oxygen. These physiological abnormalities were attributed to permanent changes in the functioning of the medullary respiratory centre. Seven out of nine patients who were convalescing after spinal poliomyelitis and who had a vital capacity of less than 50% of normal also demonstrated subnormal responsiveness to carbon dioxide as a respiratory stimulus. It appears that in poliomyelitis, as in pulmonary emphysema, peripheral mechanisms restricting chest motion may contribute to an impaired ventilatory response to carbon dioxide. The authors state that these findings support the theory that an intrinsic and sensitive function of the medullary respiratory centre is to establish the rhythmicality of breathing.

New Hearing Test in the Diagnosis of Brain-Stem Lesions.

J. MATZKER AND J. RUCKER (*Germ. med. Monthly*, August, 1958) point out that the bilateral cerebral cortical appreciation of hearing in each ear renders the conventional hearing tests almost valueless in the diagnosis of brain disease. While vestibular signs are commonly present, deafness occurs only in lesions that are so far advanced that no further diagnostic aid is required. However, in the medial geniculate body of each side are collected the auditory fibres coming from the same and the opposite sides which are thence relayed to the cortex of the same side. The authors have devised a new binaural test which consists of separating the lower-frequency and higher-frequency components of speech, which are individually unintelligible, recording them and playing them simultaneously, one into one ear of the subject and one into the other. The normal subject hears speech; but where there is an interruption of the auditory pathway, especially at the medial geniculate body, the subject cannot interpret the sounds.

Toxic Psychosis Treated with Cortisone.

F. MARS (*Presse méd.*, August 2, 1958) reports the case of a girl, aged 20 years, who, having been perfectly normal in all respects, attempted suicide by inhaling coal gas because of an unhappy love affair. She was not found for four hours; after hospital treatment she returned to her previous occupation, apparently cured, for 11 days. Without warning she then suddenly presented a neuro-psychiatric syndrome characterized by pseudo-Parkinsonism and mental confusion of the Korsakow type. Intravenous administration of procaine had no effect. Delta-cortisone was then given, in a total dosage of 500 milligrammes spread over 16 days; the patient was completely cured in less than a month. The author states that this type of treatment, which he had already suggested in 1955, and whose mode of action is obscure, seems to have the advantage of appreciably shortening the usual long course of psychoses following coal-gas intoxication. He suggests that this observation is of value, not only to the specialist, but also to the family doctor, and may avoid the need for certification.

Congenital Absence of the Odontoid Process.

L. P. ROWLAND, J. H. SHAPIRO AND H. G. JACOBSON (*A.M.A. Arch. Neurol. Psychiat.*, September, 1958) report the cases of two patients suffering from cervical myelopathy which was associated with absence of the odontoid process. It is presumed that the excessive mobility of the atlanto-axial joint afforded by this anomaly causes trauma to the spinal cord directly, or to its blood vessels and meninges, thus producing a myelopathy.

Post-Partum Mental Illness.

J. J. MADDEN *et alii* (*Amer. J. Psychiat.*, July, 1958) discuss the characteristics of post-partum mental illness, basing their study on 59 puerperal women treated at a State hospital and 57 similar patients in a private psychiatric hospital. The average age at onset of the first attack related to childbearing was 28 years in both groups, and the onset of symptoms was usually acute. Primiparæ slightly outnumbered multiparæ (60 cases and 56 cases respectively). A history of severe emotional disturbance associated with childbirth was found in 10 cases, and a history of nervous breakdowns not associated with childbearing in a further 11 cases. Thirteen patients attempted suicide, but only one, a manic depressive patient in a depressed episode, attempted to kill her child. There were many difficulties in assessing the prognosis over an average period of seven years, but their findings compared with a control group suggest that these patients have a slightly better outlook for recovery than do women of the same ages with similarly classified reactions unassociated with childbearing. Of patients with good recovery, 15 had had one or more children without further serious mental illness. Only one of the patients in this series suffered from major toxæmia of pregnancy requiring Cæsarean section, and eight others had minor degrees of toxæmia; in only three were there serious puerperal complications. The most frequently encountered form of puerperal mental illness in the series was the group of schizophrenic reactions. The authors suggest that the better outlook for patients in this group implies that the stresses entailed in achieving motherhood and being confronted with its new responsibilities act as a precipitating factor in predisposed women.

Bilateral Occipital Slow Wave Activity.

R. COHN AND J. E. NARDINI (*Amer. J. Psychiat.*, July, 1958) discuss the correlation of bilateral occipital slow wave activity in the electroencephalogram with certain disorders of behaviour. Bi-occipital slow wave activity was observed in approximately 14% of 1800 consecutive, unselected, referred patients whom they investigated. They concluded that the presence of bi-occipital slow wave activity in the epilepsies, and in a variety of other clinical neurological entities, suggests that the appearance of the bi-occipital slow wave activity in the disorders of behaviour is an indication of disturbed brain function. They suggest that the aggressive behaviour in selected patients appears to be the conditional response of a disordered brain to the exigencies of interpersonal experience.

Fatalities in Patients Receiving Chlorpromazine and Reserpine.

M. ZLOTLOW AND A. E. PAGANINI (*Amer. J. Psychiat.*, August, 1958) analyse the records of 25 patients on whom autopsies were carried out and who had been receiving chlorpromazine or reserpine at the time of death. Of these, 18 appeared to have died of incidental causes (12 from coronary artery disease and six from infectious lung disease). Three of the remainder died from acute peritonitis, due to ruptured ulcers, leading the authors to speculate that the tranquillizers may have a specific effect on the incidence of rupture of "silent ulcers". The remaining four patients died suddenly with asphyxia. The authors point out that a similar mode of death has been reported in three other papers on this topic. Three of these patients had previously had a lobotomy performed and also had a history of convulsive seizures, and one was epileptic; the authors postulate that the cause of death is rather a "masked fit" or "unnoticed convulsion" than some specific respiratory effect as suggested by earlier authors.

HYGIENE.

Protection Against Radiation Sources in Industry.

H. W. SPEICHER (*A.M.A. Arch. industr. Hlth*, May, 1958) outlines a programme of evaluation and control of the hazards to health of ionizing radiation. He considers that the first essential requirement in such a programme is the appointment of a trained officer with administrative responsibility for safe usage of all forms of radiation and radio-active materials in any organization. A brief description is then given of the sources of ionizing radiation and their characteristics. The damage caused by ionizing radiation is referred to as being due to the ionization of molecules of either organic or inorganic origin. Some molecules are composed of ions that are bonded by electrostatic attraction and others by covalent bonds. When such molecules are decomposed by radiations, electrically charged particles are formed which can recombine in a number of different ways to cause new molecules that may have toxic effects on normal tissue. Damage is caused by radiation from external sources and from internal sources. The latter are particles of radio-active material that have entered the body through the lungs, alimentary canal or breaks in the skin. The author considers that pre-employment medical examinations should include a complete blood examination, a differential white count and an X-ray examination of the chest. Periodic examinations should include estimations of radio-active substances in urine to evaluate the intake of these substances by breathing or ingestion. Methods of monitoring or measuring the radiation from sources of ionizing radiation and ways of using various personal protective devices are described. The author then gives practical details of shielding, radio-active waste disposal, ventilation, decontamination, storage of radio-active materials and control of accidental fires in areas where radio-active material is present.

Chlorinated Water and Enteric Viruses.

S. KELLY AND W. SANDERSON (*Amer. J. publ. Hlth*, October, 1958) report a study of the sensitivity of a number of enteric viruses to chlorine solutions. Previous studies showed that while adenovirus type 3 was similar to *Escherichia coli* in its reaction to chlorine, Coxsackie virus A2 required seven to 46 times more residual chlorine for inactivation. The authors' present study dealt with poliomyelitis viruses and other Coxsackie viruses. Technical details of the study are given. The results indicate that complete inactivation of enteric viruses (beyond the limit of detection) was not achieved by the usual conditions for bacterial disinfection of water supplies, i.e. free residual chlorine concentrations of 0·2 part per million for 10-minute contact at pH 7. Concentrations of free residual chlorine of from 0·2 to 0·3 part per million inactivated viruses after contact periods of 30 minutes. Contact periods of at least four hours were necessary for inactivation by combined residual chlorine concentrations of 0·7 part per million. Factors which affected the inactivation of viruses were strain, pH level, free residual chlorine concentration, exposure time and temperature. Strains in decreasing order of their sensitivity to chlorine were as follows: Coxsackie B5, poliomyelitis virus 1 (Mahoney), poliomyelitis virus 2, Coxsackie B1, poliomyelitis virus 3 and poliomyelitis virus 1 (MK 500). The results suggest that inactivation of enteric viruses in water at pH 7, 25° C., requires a minimum free residual chlorine concentration of 0·3 part per million for contact periods of at least 30 minutes; at higher pH levels or lower temperatures, more intensive chlorination is necessary.

Portable Tissue Culture Laboratory.

J. MELNICK (*Amer. J. publ. Hlth*, September, 1958) describes a field laboratory investigation of a poliomyelitis epidemic in British Guiana. The use of tissue cultures which can be handled under field conditions allowed viruses to be isolated and typed within a few days. This was of value in establishing two types of poliomyelitis virus as causative agents, and in suggesting that some of the reported cases might be the result of infection with enteroviruses other than poliomyelitis virus. With portable plastic panels and dropping pipettes, complement fixation tests were set up for performing antibody determinations overnight on diagnosed and suspected cases of the disease. The virological and serological tests were of immediate value to local public health officials in establishing poliomyelitis infection, or in offering no confirmation of the diagnosis of poliomyelitis. The author, in a discussion of the epidemic, suggests that an improved standard of living conditions and sanitation is indicated by a lowering of the infantile mortality rate and the fact that poliomyelitis is becoming an epidemic rather than an endemic disease.

Constant Fluoride Concentrations.

G. S. SPITZ, F. TAYLOR AND W. HARRIS (*Amer. J. publ. Hlth*, December, 1958) report the results of investigations into the precision with which fluoride content levels were maintained in three fluoridated water supply systems. The authors state that approximately 32 million people in the United States drink water to which prescribed amounts of fluoride have been added, and there is evidence that fluoride when present in less than optimal amounts provides less benefit in the prevention of dental caries than it should. Methods of fluoridation and methods of sampling are described. In one city fluoride readings were constant at the optimal level with a small standard deviation over a number of years. Average fluoride content in the second city fell far short of the objective, and a large variation was found in the daily readings during the period for which data were collected. Average fluoride content in the third city fell short of the objective during the initial test period and showed wide variation. During a succeeding test period in which efforts for improved controls were made, the average fluoride content more nearly approximated the objective and individual readings were much less variable. The authors suggest that constant supervision of fluoridated water supplies is necessary to achieve anticipated reductions in dental caries. They state that lack of supervision can only bring undeserved discredit to one of the principal public health measures of this era.

Carbon Black.

C. NAU, J. NEAL AND V. STEMBRIDGE (*A.M.A. Arch. industr. Hlth*, December, 1958) investigated the effect of skin contact with carbon black. This substance is usually produced by the burning of gas or oil in an inadequate supply of air and is used in increasing amounts in industry, particularly in the rubber industry. The details of the investigations are given. From the results obtained, the authors have arrived at the following conclusions: Carbon blacks as manufactured and used produce no observable harmful effects as a result of skin contact. Carbon blacks have adsorbed a component which, when free and applied to the skin of mice, produces skin cancer. The adsorbed component is ineffective as a carcinogen. Carbon blacks can adsorb effectively known carcinogens such as methylcholanthrene and 3,4-benzpyrene and by such adsorption eliminate or reduce the carcinogenicity of these substances.

Toxicity of Phosphine.

R. HARGER AND L. SPOLYAR (*A.M.A. Arch. industr. Hlth*, December, 1958) report that an employee in an acetylene plant died probably as the result of poisoning by phosphine gas. Metallic phosphides react with water or water vapour to produce phosphine gas and the hydroxide of the metal. Ferrosilicon and calcium carbide contain small amounts of calcium phosphide. Aluminium phosphide is used as a grain weevil fumigant. Sodium phosphide is employed for lighting buoys at night. The employee was found dead in the generator room. The cause of death, as determined by a post-mortem examination, was acute pulmonary oedema, due to an undetermined cause. It was estimated that the air in the generator room contained from 2% to 12% of acetylene, less than 10 p.p.m. of hydrogen sulphide, about 8 p.p.m. of phosphine and minute amounts of arsine. The authors consider that the cause of death, as indicated by the analytical results, the case history and the post-mortem findings, was poisoning with phosphine gas, and that the inhalation of high concentrations of acetylene gas may have been a contributing factor.

Rheumatic Fever in Minnesota.

A. ROSENFIELD (*Amer. J. publ. Hlth*, December, 1958) describes the result of an investigation into the incidence of rheumatic fever in Minnesota, carried out by sending a *questionnaire* to 3063 doctors, 50% of whom returned *questionnaires* with details of 2297 cases of rheumatic fever in a twelve-month period. During the previous five years an average of only 187 cases *per annum* had been reported. Investigation of 13% of the cases reported showed that 80% appeared to be rheumatic fever but 10% failed to meet Jones's criteria. These results suggested that 2600 patients with rheumatic fever were treated in the State of Minnesota during 1955.

Brush Up Your Medicine.

MANAGEMENT OF INFECTIONS OF THE URINARY TRACT.

A NORMAL URINARY TRACT in a healthy person does not readily become infected. The factors predisposing to infection may be general as well as local. More than one case comes to mind in which a troublesome infection resisted treatment by all the appropriate antibiotics, but finally cleared up after a holiday. Locally, almost any abnormality of any part of the urinary tract, congenital or acquired, seems to predispose to infection, and particularly any lesion of an obstructive type which prevents proper emptying of kidney or bladder. Recurrent or persistent infection is then, in most cases, a focal infection with recurring general spread.

Ætiological Factors.

In the female, by far the most common site of trouble is the urethra, and this is often the last place thought of and the place least frequently investigated. In some women, the urethra appears to permit infection of the genital tract to gain rather ready access to the bladder, and in many cases recurrent cystitis has been cleared up by cauterization of an infected cervical erosion. Stricture of the female urethra is a common condition, though it is hardly mentioned in the ordinary medical and surgical text-books, perhaps because even when the stricture causes quite gross narrowing of the urethra, patients rarely note any impairment of urinary flow. However, every practitioner must have seen patients sent for investigation of the urinary tract, in whom no definite abnormality was found, but who, nevertheless, experienced temporary improvement or were apparently cured after a cystoscopic examination. These patients were relieved by dilatation of their urethral stricture. Chronic urethritis is often associated with a stricture, as either a cause or a consequence of it. Infection may persist in the paraurethral glands.

Incoordination or achalasia of the bladder neck, which closes before emptying is complete, occurs both in children and in adults, especially elderly females, and a test for residual urine will sometimes provide the answer to a problem which extensive investigation of the upper part of the tract has failed to solve. Cystocele may be a cause of residual urine.

Lesions of the central nervous system may cause dysfunction of the bladder or the sphincteric mechanism, and may occasionally present as an acute or persistent urinary infection. A quick test of the tendon jerks, plantar reflexes and sensation over the sacral area should be part of the routine examination.

To attempt to give a complete list of abnormalities above the level of the urethra predisposing to infection would be to enter on a dissertation on all the pathological conditions which may occur in each part of the urinary tract. One condition, however, does deserve mention, and that is tuberculosis. A "silent" tuberculous lesion in a kidney may act as a focus for recurrent secondary coliform infection.

Diagnosis.

In the male a bout of urinary tract infection, in the absence of some definite focal lesion, is rather uncommon. The prostate is the commonest organ involved as a focus of persistent infection, but a word of caution is necessary here. There is little doubt that a tender, painful prostate is found in young men in the absence of infection, and the word "prostatitis" is as much a misnomer for this condition as is the word "mastitis" for a very similar condition in the female breast. Also it should be noted that a few pus cells are to be seen in fluid expressed from the normal prostate, and the presence of threads in the urine after prostatic massage indicates inspissated secretion and not necessarily anything more.

The palpation of a localized abscess or the irregular firm depressed area left after such an abscess has discharged, or the expression of purulent fluid, characteristic appearances through a panendoscope, and the recovery of the infecting organism, provide evidence of infection of the prostate.

A bout of cystitis or prostatitis is often the presenting symptom of a urethral stricture which has closed down gradually over the years.

In infections of the upper part of the urinary tract, the term "acute pyelonephritis" is now fortunately replacing the old misleading name "acute pyelitis". The inflammation of the renal pelvis itself is quite an unimportant feature of the pathology of this condition. The high temperature is associated with infection of the renal parenchyma, and the rigors are associated with bacteriæmia.

In the familiar case of acute pyelonephritis, tenderness over the kidney is often extreme and is a cardinal sign. However, in patients who contract pyelonephritis following catheterization or other surgical procedures on the renal tract, this renal tenderness is often completely lacking. If such patients have a temperature over 101° F., and if testes, prostate and lungs show no abnormal signs, then the diagnosis of pyelonephritis is made and the need for immediate treatment is urgent, for irreparable damage to the kidney rapidly occurs.

Chronic pyelonephritis is a condition to which not enough attention has been paid. Recurrent bouts of pyelonephritis, acute or subacute, cause progressive damage and scarring in the interstitial tissue of the kidney. In some cases infection may smoulder on in the interstitial tissue without obvious symptoms of infection. Irregular and progressive destruction of kidney tissue finally ends in a condition closely similar to the end result of chronic nephritis. There is no doubt that many uræmic patients in the medical wards of our hospitals carrying the diagnosis of chronic nephritis in its terminal stage have been, in fact, suffering from chronic pyelonephritis, and thus their illness could in many cases have been prevented. Isolation of the organism in this disease is often difficult, and usually a culture of micro-organisms from the urine can be obtained only at the onset of an exacerbation of the infection. The history of recurrent bouts of urinary infection and rather characteristic X-ray signs are grounds enough for diagnosis in most cases. The typical changes seen in a pyelogram are an over-all decrease in the size of the kidney and the thickness of the renal tissue, irregular blunting of the calyces without much dilatation, and narrowing of the calyceal necks. Characteristically, the changes are uneven, some of the calyces showing the rounded or blunted appearance more definitely than others, and in the late stages narrowing of the calyceal necks proceeds to the stage of complete stenosis, so that calyces apparently disappear. Treatment of the established condition is not easy, and the main object of bringing this subject to notice here is to emphasize the need for prevention. Effective prevention means an adequate course of treatment and a follow-up investigation of all patients with urinary tract infection, to make sure that the infecting organisms have been permanently eliminated.

Treatment.

Drugs can be divided into two groups, those which it is reasonable to prescribe empirically and those which should not be prescribed without preliminary cultural studies of the urine. In the first group come the sulphonamides (of which "Urolucosil" and "Gantrisan" are probably the most useful), and "Mandelamine". For patients in whom infection is serious, "Chloromycetin" may be added to this list. "Chloromycetin" now has the widest range of any of the antibiotic drugs, and of them all it is the drug to which organisms are least likely to develop resistance.

The remainder of the antibiotics and "Furadantin" are best used only if a sensitivity test has been carried out on the urine. Their effectiveness on the organism in any particular case is quite unpredictable, and bears no certain relationship to the bacteriological classification of the organism involved.

In so far as immediate treatment of an acute attack is concerned, patients fall into one of two groups. In the first group fall patients with symptoms of cystitis, acute or subacute, and in the second group, to the symptoms of cystitis are added the symptoms and signs of acute toxæmia with a high temperature and rigors.

In the first group—that is, when pyrexia and other symptoms and signs of general toxæmia are absent—it is reasonable to assume that the organisms are confined within the collecting system of the urinary organs, and will therefore respond to treatment aimed at rendering the urine inimical to them. Since drugs such as the sulphonamides are concentrated by the kidneys, quite a small dose of such a drug reaches a high concentration in the urine, and is just as effective as a larger dose.

On the other hand, a high temperature means that infection of tissue is occurring, and not only is effective treat-

ment urgent in order to prevent permanent damage or abscess formation, but the dosage of the drug used must now be of the same order as that employed for severe infection of other parenchymatous organs, such as the lungs in pneumonia. Full dosage of either sulphonamides or "Chloromycetin" is indicated at once. However, in acute cases, before the first dose of any such drug is given, urine should be collected for cultural investigation and tests of sensitivity to antibiotics, and an urgent report should be requested. Then, if the patient fails to respond to the drug given empirically, administration of the appropriate antibiotic can be begun within 12 hours. If urine for culture is not taken at this time, then there may be serious delay, and irreparable damage may be done by the infection before the appropriate treatment is applied.

In the common pyelonephritis due to the coliform bacillus, the importance of alkalinization of the urine should not be forgotten. Older practitioners will remember the dramatic fall in temperature which resulted from the use of sodium bicarbonate alone in the days when alkalis were almost the only drugs available. "Mandelamine" is not the drug for these acute cases, and indeed is contraindicated, since, when the kidney is acutely inflamed, it can cause hæmaturia, and it acidifies the urine when alkalinization is desirable.

When the acute phase of infection is controlled, a common mistake is to stop treatment too soon. Whatever drug has been used to control the acute or subacute attack, it should be a fixed rule to follow this with a sulphonamide such as "Urolucosil", or with "Mandelamine", for a period of at least two or three weeks. If this were always done, many cases of recurrent and troublesome infection would be prevented.

Finally, the last and not the least important, and certainly the most neglected, part of the treatment is the follow-up examination. Patients should report back for microscopic examination of the urine two or three weeks after all treatment has ceased, and should again report back three to six months later. It is only by such follow-up examinations that chronic pyelonephritis will be prevented or treated at a stage when the disease can be arrested.

Persistent or recurrent infection in the urinary tract at once leads to a suspicion of some abnormality, but enthusiasm for investigation must be tempered by common sense. Such investigations are both expensive and trying and by no means always harmless. No hard and fast rule can be given; however, in the female it is usually reasonable to treat two attacks of infection empirically, but a third attack of infection or a persistent infection after two courses of treatment indicates urological investigation. In the male, not more than one attack should be treated empirically, and in fact, in the male, the presence of a urinary tract infection in itself is a reasonable indication for urological investigation, since an infection rarely occurs in the absence of some abnormality.

Routine investigation should begin with a cultural study of the urine. In the male, a mid-stream specimen is required and a catheter should not be passed. For the female, a catheter specimen is necessary. In taking urine for culture in this way, care is needed not only to avoid introducing infection into the patient's bladder, but also to avoid introducing any traces of antiseptic into the urine specimen. The bacteriologist is often blamed for not growing an organism which was present in the centrifuged deposit when, in fact, the blame lies on the person who collected the urine, which was contaminated by traces of one of the more efficient modern antiseptics.

Catheterization should always be followed by a short course of a sulphonamide or "Mandelamine". In a number of cases I have seen acute cystitis follow diagnostic catheterization when the urine collected at the time was free of infection.

In female children the mother may often be able to collect a mid-stream specimen of urine quite suitable for bacteriological study, and catheters should be avoided if this is at all possible.

The next step is intravenous pyelography. When this is ordered, there should always be a request for a film of the bladder region immediately after urine has been passed. This may show residual urine when it is least expected, and not infrequently this is the only positive finding at this examination. As a routine films are taken during expiration, but it is always an advantage also to have one of the films taken during inspiration to show mobility of the kidneys; this film will also show whether an opaque area overlying the kidney shadow is in the kidney or not. This inspiration film involves no extra trouble, and may well save retrograde pyelography later.

A cystoscopic examination now follows, and a panendoscope should be available for examination of the urethra and prostate at this time.

It is suggested that retrograde pyelography should never be carried out except when it is indicated by preliminary intravenous pyelography. Retrograde pyelography gives a denser X-ray shadow, but in general it provides less useful information than does a good intravenous pyelogram, and it is both unpleasant and by no means free of risk. Urethrography, cystography or cystometrography may be needed in special cases.

At the time of cystoscopic examination of a female patient, particular note should be taken of the ease of introduction of the instrument. The normal female urethra admits a cystoscope easily, and if the urethra offers resistance to the passage of the instrument, then a stricture should be suspected. If no other abnormality is found, then at the end of the examination the urethra should be dilated to admit a size 28 or 30F cystoscope, and the patient be asked to report in one to two weeks' time.

After this dilatation, many patients will comment on their increased comfort and the relief of dysuria, and the suspicion that a stricture has been the cause of the trouble is confirmed. Further urethral dilatations at intervals first of weeks and then of months are now indicated. In many of these cases the condition responds well to dilatation, and in many an apparently permanent cure can often be attained after relatively few dilatations.

There still remains a difficult residue of patients in whom an extensive search fails to reveal any significant local abnormality. An undiscovered focus of infection in the urethra is still a possibility; but many of these patients are of the congenitally inadequate type, with many other complaints and troubles. Here it seems that poor general resistance to infection is a predisposing factor. The best that can be done in such cases is to try to improve the patient's general health by attention to diet with vitamin supplements, adequate rest and a holiday. At the same time the patient is put on a drug such as "Urolucosil" in a dosage of, say, one tablet three times a day for six months or more. A good regime for any persistant infection is to order "Urolucosil", one tablet three times a day, with a small level teaspoonful of bicarbonate of soda, to be taken from Monday to Thursday of each week, and "Mandelamine", four tablets three times daily, for the remaining three days of the week; this may be continued indefinitely. The repeated change of urinary pH as well as the change of antiseptic is not liked by most bacteria, and the risk of drug reaction is minimized.

In the male, prostatitis often presents a difficult problem. The logical way of managing this condition is first to try to isolate the organism. This can often be done by culture of the first urine passed after prostatic massage. If pus cells and organisms are seen on direct examination of the smear, and if the organism grown corresponds morphologically to the one seen in the smear, it is more than likely that this is the pathogen involved. A prolonged course of the appropriate antibiotic may now be given. While the patient is taking the drug, the prostate should be massaged daily, with the object of emptying out any pockets of secretion or pus in which the organism may survive in a site where the antibiotic cannot get access to it. In a good many cases this treatment will clear up the infection.

There remains, however, the low-grade chronic prostatitis which does not respond to the treatment suggested. In a few of these cases the infection may cause severe symptoms with bouts of pyelonephritis or epididymitis, and in such cases surgical treatment may be required. However, in many the infection does little harm, and the condition is perhaps comparable to mild chronic nasal sinusitis. Repeated prostatic massage serves only to focus the patient's attention upon his prostate. In many of these cases the reasonable treatment is simply to reassure the patient, as the real disability is not due to the infection, but to the mental distress occasioned by the idea that he has some terrible disease.

Conclusion.

In conclusion, a few points may be reiterated. In the female the urethra is the commonest site of persistent infection, and stricture of the female urethra is both common and easy to treat.

Chronic pyelonephritis is a real condition, and far more common than is generally realized. The only effective treatment is prevention, and this is achieved by ensuring that urinary tract infections are completely cleared up.

With the possible exception of "Chloromycetin" in emergencies, the antibiotics should be used only after cultural tests. A course of an antibiotic should always be followed by several weeks of an antiseptic such as "Mandelamine" or a sulphonamide, a good regime being to alternate these drugs at intervals of a few days.

Finally, Ambroise Paré's comment that "I treated him and God healed him" is still true. With all the powers and virtues of our new drugs it is the patient's own defence mechanism which finally eliminates infection, and the importance of attention to general health with a holiday during late convalescence can hardly be exaggerated.

NOEL J. BONNIN.

Adelaide.

On the Periphery.

CEREMONIAL CIRCUMCISION.

RECENTLY I spent two weeks at the aboriginal mission on Mornington Island. The question of reestablishment of the old rite of circumcision had been exercising the minds of the older men of the Lardil tribe for some twelve months, for this old-time custom had lapsed for many years. My visit must have seemed to them a golden opportunity for testing out "the white man's way" of the operation, and so they approached me to find out if I would perform it, and I willingly agreed.

FIGURE I.
The two doctors.

Circumcision is, of course, part of the initiation ceremonies which introduce the lad from boyhood to manhood, and was usually performed when the young fellow was about sixteen years of age. This part of the whole ceremonial lasted two days, and news of its occurrence was given to scattered parts of the tribe by a messenger who carried the properly marked message stick, and he announced the date and place of the initiation. Such a message stick was on this occasion duly sent to the mission house, and I kept it for the university.

There was a hold-up at the start, for the old custom decreed that the initiate should have been approached by a particular relative, but for some reason this had not been arranged correctly, and the initiate objected, but was eventually persuaded to carry on.

First he was surrounded by a number of the old men, who gave him sound advice and warning as to what would be expected of him in the future. He was then taken away for a short time by one of the relatives, and the old men again sat in a circle; they sang the proper song in which they called everybody, men, women and children, to attend the ceremony. The initiate was then brought back and surrounded by the old men, and while sitting there, his father-in-law ran in and boxed his ears and shook him, and then yelled out, telling the elders to carry on with the ceremony. They all then stood up and sang to an accompaniment of clattering boomerangs, and after this was over, several of them plastered the initiate all over with red ochre. His maternal grandfather then put on him a forehead band of yellow with a red centre, and on each side from it, in front of each ear, hung three wallaby teeth. A cousin then wound a considerable length of hair string around the initiate's waist. After that a number of the men took him into the bush, where they were all painted white; and from the bush the "dumb man" ran out carrying spears and a fishing net and sat down near the old men, but he would not talk, answer any questions, or even smile. After a short interval he went back to the bush.

FIGURE II.
Tiptoe, in a ceremonial dance.

Shortly afterwards there appeared a line of men, painted with white clay, winding down a small rise, with the initiate in their midst, tied to a cousin by a length of hair string. His head was covered with a pointed hat made of short green branches. As this line of men wound down, they were hissing, shaking boomerangs, and performing definite movements proper to the occasion, but when they crouched now and again, the initiate stood erect. Gradually they approached the group of old men who were waiting for them. In the meantime, his women tribal relatives had been dancing and singing (four were all painted with red ochre) and calling on the old men to bring out the initiate. Their dancing was

FIGURE III.
Ceremonial dance.

more in the nature of a shuffle, jumping two feet forward at the same time. The old men all then bunched around the initiate, who was raised onto the shoulders of his tribal grandfather, and they handed him over to the women for safe keeping till the next day's climax.

The male relatives concerned went away to the sacred ground, where they were properly decorated for their later dances and songs. You will see from Figures II and III that small balls of white feathers were stuck on them, and as this was a sacred ceremony, blood was used as an adhesive. This was provided by one of the relatives who cut

a small vein in his forearm (for ordinary occasions, a mixture of honey and water was used to stick the feathers on). These feathers were from three birds—a jabiru, a sea eagle and a pelican. They were all rolled together and chopped up finely, again and again, and then formed into small balls with white clay and water. The last daylight activity occurred about sundown, when the previous group of old men called the tribe together again, and shouted out "*jaw*". This was the signal for three decorated men at a time to appear on the top of the small rise, and after per-

FIGURE IV.
The operating table.

is [illegible] certain antics, to approach the old men, who, when the second lot had passed, closed the day's proceedings by hitting the ground with a fighting stick. The dances and songs later in the evening were sacred, and no women were allowed to see them, but the natives helped us to record the dances on the movies by repeating them for us in the daylight.

FIGURE V.
The operation.

The next day was the one appointed for the operation. This was apparently performed at sunrise, but as I wanted to get some photographs of the whole procedure, we compromised by putting it off till 7 a.m. Everybody went to the sacred ground for its performance. I used some "Xylocaine" as a local anæsthetic, and had no need of the sting-ray spine which was suggested as a knife, as I had a set of small instruments with me. Of course, the local anæsthetic acted well, and the remark was made that of old time they had to have three or four men to hold down the initiate. My instrument table was a box, but my operating table was four tribal brothers lying face-down, flat on the ground (Figure IV). You will notice that they managed to get a large canvas sheet to lie on. The patient had to be carried ceremonially to and from the operating table, and when he was there, I had to get the table members to move apart a little, so that I could get at the patient. It was rather a back-breaking job (Figure V). However, all went well, and I handed the foreskin, which was sacred, to the father-in-law, who wrapped it up in paper bark, and tied a feather onto one end of the parcel. Of old time the wound was dressed with hot ashes, clay, bird fat and paper bark, and the victim kept quiet for two or three weeks. My small dressing of one-inch gauze and *Tinctura Benzoini Composita* impressed them all considerably, and they all voted "white man's way is a good way"; the superintendent's comment was: "There'll be a crowd of them now wanting to be done."

L. P. WINTERBOTHAM.

Brisbane.

Out of the Past.

In this column will be published from time to time extracts, taken from medical journals, newspapers, official and historical records, diaries and so on, dealing with events connected with the early medical history of Australia.

USE OF STIMULANTS AT MELBOURNE HOSPITAL.[1]

[From the *Australasian Medical Gazette*, February, 1883.]

SOME weeks prior to the annual hospital election, the question of stimulants came up again, and it terminated in a return being furnished of the quantity ordered severally by the honorary staff, and the proportionate mortality following. The result, as judged by the mortality, was in favour of the employment of stimulants. This conclusion was afterwards traversed by the anti-stimulant party, but not, as I think, with success. Apart from this aspect of the stimulant question, it is a matter yet to be determined whether a lay committee shall be permitted to dictate to the medical officers of a hospital the kind of treatment they shall adopt: for if dictation be allowed in respect of alcoholic stimulants, it will be nothing surprising if it extend presently to drugs.

Correspondence.

"FOLLOWING."

SIR: Following "Following" (MED. J. AUST., February 7, 1959), it is of philological interest to note that the Oxford Dictionary (compiled by that illustrious interpreter of the King's English, the late H. W. Fowler, followed later by his brother, the late F. G. Fowler) gives, as one of the meanings of the word "follow", the following definition: "Come after, in Order or Time."

Fowlering—pardon—following Dr. Greene's proposition that "following" is not a preposition, I am provoked into posing a rhetorical question, even though the form of the question would probably not be met with approval by Dr. Greene: "So what?"

The word "follow" can be used as an intransitive verb as well as a transitive verb, and in my view the use of the present participle as an adverbial phrase, connoting "subsequent to", is a legitimate usage and should be acceptable to anyone but a pedant.

Despite my mild criticism of Dr. Greene's opinions, I have no doubt whatever that he's a jolly good follow.

Yours, etc.,

ARTHUR D'OMBRAIN.

135 Macquarie Street,
Sydney,
February 12, 1959.

CARDIAC SURGERY, PAST AND PRESENT.

SIR: Your editorial on this subject in the Journal of Saturday, February 21, 1959, gives an excellent survey of the present position of cardiac surgery. Most of those working in this field would agree with the writer of your editorial that the development of pump oxygenators and perfusion techniques should be undertaken only in centres

[1] From the original in the Mitchell Library, Sydney.

with an adequate supply of clinical material, with established cardiological units experienced in clinical and more specialized diagnostic techniques, with the facilities of an animal laboratory available, and, one might add, with successful experience in the simpler forms of open heart surgery under hypothermia, such as pulmonary valvotomy and the closure of uncomplicated atrial septal defects. When this stage is reached, the next logical development is intraventricular surgery using cardio-pulmonary bypass and some form of extracorporeal circulation, and I cannot agree with the writer of your editorial that this development should be confined to two units each in Sydney and Melbourne. In Sydney at the present time there are four major cardiological units in teaching hospitals which should reasonably undertake this work, and in the two units with which I am associated a good deal of preliminary experimental work in the animal laboratory has already been carried out. The one unit in Sydney which is at present applying perfusion techniques in clinical practice can do no more than scratch the surface of the demand in the congenital heart disease field alone.

Apart from the correction of congenital cardiac defects, it seems clear that further advances in the surgical treatment of aortic and mitral valve disease will depend on the use of cardio-pulmonary bypass. Apart from the heart altogether, there is tremendous scope for perfusion techniques in other organs and body territories. Bearing these facts in mind, one unit skilled in these techniques per million people should not be too much, and on that basis one can expect that eventually there may be four such units in Sydney, three in Melbourne, and one each in the other mainland capital cities.

Perfusion techniques have come to stay, and it would be unfortunate if the opinion expressed by the writer of your editorial should discourage the development of adequate facilities in this country.

Yours, etc.,

Douglas Stuckey,
Cardiac Investigation Clinic, Royal North Shore Hospital of Sydney, Congenital Heart Disease Clinic, Royal Alexandra Hospital for Children.

175 Macquarie Street,
Sydney,
February 28, 1959.

THE PROBLEMS OF ADOLESCENCE.

Sir: I read with interest the papers from the South Australian symposium on "The Problems of Adolescence" (Med. J. Aust., February 21, 1959). It is evident that the symposium was chiefly concerned with adolescents who display "those problems which most disturb the community, such as delinquency". This is a timely and necessary study, but it is important to remember that adolescents present problems other than delinquent behaviour, and these problems offer a major challenge to physicians and others interested in research and thoughtful treatment. Acne, obesity, orthopædic disorders, disturbances of growth and development, scholastic failure, dysmenorrhœa and enuresis frequently occur in adolescence, and nobody could claim that these conditions are thoroughly understood or adequately handled. Epilepsy, heart disease, diabetes, brain damage and mental retardation all have special implications for the adolescent patient, and an alert physician may materially assist young patients to cope with such handicaps.

Few adolescents, however, present purely physical ailments, and parents often ask the family doctor to help fearful, rebellious, defiant, dependent, moody, or "highly strung" children. Psychoses, gross character disturbances and severe neuroses are seen, but the majority of adolescent patients display "normal abnormalities" of adjustment. A member of the symposium stated that "problems are almost the whole of adolescent life; some of them are enjoyably resolved, but most of them need help of a non-directive kind". How often does the harassed family doctor provide this sort of help? In fact, how often is he willing or equipped to try?

Wisdom, experience and healthy common sense will certainly enable a doctor to offer an adolescent support and encouragement; but facile reassurance that "it's just a phase" or "he'll grow out of it" is useless, dangerous and a waste of time. Young people are remarkably responsive to the interest of sensitive and objective adults, and they present excellent opportunities for the practice of the "total care" which it ought to be our privilege to provide.

All of which is intended to emphasize the need for better medical care for adolescents. Doctors need better training in the fundamentals of personality development and malfunction, and a clearer understanding of their role in the management of everyday problems. Further research is needed in many areas, and a better liaison with other professions is long overdue. With the benefit of modern training and knowledge, the physician should fill an invaluable role in the prevention of physical, emotional and social maladjustment and the promotion of bodily and mental health. That this can be accomplished is shown by the rapid expansion of clinics for adolescents in the United States and other countries. The first was established in Boston in 1952, at the Children's Medical Centre and Harvard Medical School, and its success has led to the development of others in New York, Oakland and many other cities. These are not child guidance units, but general medical clinics in which the physicians are trained to deal with all aspects of adolescence, including less severe emotional disturbances. The clinics have also proved to be a valuable stimulus to research and training in adolescent medicine.

There is a growing need for similar developments in large Australian cities. One hopes that the medical profession and the general public will be able to see beyond the confines of "juvenile delinquency" to a much broader field which encompasses all the needs of young people; physicians, perhaps, should lead the way.

Yours, etc.,

Murray Williams.

Mitchell,
Queensland,
February 26, 1959.

Royal Australasian College of Surgeons.

ADMISSION OF NEW FELLOWS.

The following, having satisfied the Court of [redacted] were admitted to fellowship of the Royal Australasian College of Surgeons by the Council on February 20, 1959: Dennis Deane Arnold, John Robert Badger, John Sadler Barnett, Alec Graeme Bond, William Sydney Egerton, Richard Peter Freeman, Ronald Edward Gristwood, John Keith Henderson, Desmond Garvan Hurley, Kevin Johns, Desmond David McGuckin, Ian Lumsden McVey, Roland William Donald Middleton, John Stanley James Morley, James Kevin O'Reilly, Colin Gordon Pauli, Edmond Graham Roberts, Walter Henry Collins Scott, Robert Darlow Smith, Geoffrey William Sprigge, Stanley Henry Watson, David Zuil.

FACULTY OF ANÆSTHETISTS: ADMISSION OF NEW FELLOWS.

The following, having satisfied the Court of Examiners, were admitted to fellowship of the Faculty of Anæsthetists of the Royal Australasian College of Surgeons by the Council on February 20, 1959: Leon Richard Alfred Bryan, Max Adderly Griffith, Allan Metcalfe Hall, Brian Thomas Jordon, Patrick Alan Maplestone.

Post-Graduate Work.

THE MELBOURNE MEDICAL POST-GRADUATE COMMITTEE.

Programme for April, 1959.

Courses for Higher Qualifications.

The Melbourne Medical Post-Graduate Committee will conduct a course in microbiology, suitable for candidates for M.D., M.S. and post-graduate diplomas. This will commence at the bacteriology department, University of Melbourne, on April 7, 1959, and will continue on Tuesdays at 2.15 p.m. for 20 weeks. Enrolments, together with the fee of £10 10s., should be lodged with the Committee by March 24.

Attention is drawn to the following courses, to be conducted by other organizations, which will commence in April.

From April 7 till July 14, the Department of Mental Hygiene, Victoria, will conduct a post-graduate course in

psychiatry at the Training Centre, Royal Park Receiving House, on Tuesday evenings from 8 to 10 p.m. The first two months will be devoted to a symposium on alcoholism, and general topics will follow in June and July. Inquiries should be addressed to the Chief Clinical Officer, Mental Health Research Institute, Poplar Street, Royal Park, N.2. There is no fee for the course, and all registered medical practitioners are invited to attend.

The psychiatry course of the Australasian Association of Psychiatrists, which commenced in March, will continue on Thursday evenings. Details of this course were given in the March programme.

Commencing on April 13, the Victorian Branch of the Ophthalmological Society of Australia will conduct a course in ophthalmic medicine and surgery and ocular pathology, consisting of about 80 lectures, suitable for candidates for Part II of the D.O. The lectures will be held chiefly in the late afternoons at the Eye and Ear Hospital. The fee for the course is £31 10s., and enrolments should be made through the Post-Graduate Committee by March 24.

Courses in anatomy, physiology and pathology for Part I of higher qualifications will continue at the University departments.

Those interested in a course in radiodiagnosis should get into touch with the Post-Graduate Committee.

Details of the course in medicine, commencing at St. Vincent's Hospital on June 1, will be published shortly.

Refresher Course in General Medicine and Surgery.

A full-time refresher course will be conducted at Prince Henry's Hospital by the honorary medical staff from April 27 to May 1 inclusive. There will be four sessions daily, commencing at 9 a.m. and finishing at 5 p.m., consisting of lectures and lecture-demonstrations. The fee for this course is £9 9s., and enrolments, if possible on the Committee's forms, should be lodged with them before April 13. Detailed programmes will be available from the Committee, showing as well arrangements for lunch and parking. The course will conclude with a clinical demonstration at the Eye and Ear Hospital on Saturday, May 2. This will be open to all members of the medical profession.

Training in Emergency Surgery for General Practitioners.

Country practitioners who wish to further their knowledge in emergency surgery are advised to get into touch with the Post-Graduate Committee regarding the facilities that exist in this State by which they may attend the major metropolitan teaching hospitals for training for indeterminate periods.

Country Courses.

Wangaratta.—On April 11, at the Base Hospital, Wangaratta, the following course will be held: 2 p.m., "Diverticulitis", Mr. A. Kelly; 3.15 p.m., "Neonatal Distress", Dr. W. H. Kitchen; 4.45 p.m., "Hormones in Gynæcology", Mr. R. G. Worcester. The local secretary is Dr. M. Rohan, 18 Docker Street, Wangaratta.

Warracknabeal.—On April 11, at Warracknabeal, in the hospital lecture room, the following course will be held: 2 p.m., "Hormones in Gynæcology", Dr. B. Kneale; 3.15 p.m., "Lumps in the Breast", Professor Maurice Ewing; 4.45 p.m., "Management of Diabetes", Dr. H. P. Taft. The course will be followed by dinner and a quiz session. The local secretary is Dr. J. D. Searby, Warracknabeal.

Ballarat.—On April 23, at Craig's Hotel, Ballarat, at 8 p.m., Professor R. R. H. Lovell will lecture on "Current Concepts of Steroid Therapy". The local secretary is Dr. N. Pescott, 626 Sturt Street, Ballarat.

Flinders Naval Depot.

On April 15, at Flinders Naval Depot, at 2.30 p.m., Mr. A. B. Alder will lecture on "The Investigation of Urinary Tract Infection". This lecture will be given by arrangement with the Royal Australian Navy.

Overseas Lecturers.

Professor Sir Stanley Davidson, physician, of Edinburgh, will visit Melbourne from April 3 to 6 inclusive, and the following programme has been arranged for him:

April 3: 9.30 a.m., ward round at the Royal Melbourne Hospital with Dr. Ian Wood; 1 p.m., lecture to Residents' Club at the Royal Melbourne Hospital, "Anæmia and Operations on the Gastro-Intestinal Tract".

DISEASES NOTIFIED IN EACH STATE AND TERRITORY OF AUSTRALIA FOR THE WEEK ENDED FEBRUARY 14, 1959.[1]

Disease.	New South Wales.	Victoria.	Queensland.	South Australia.	Western Australia.	Tasmania.	Northern Territory.	Australian Capital Territory.	Australia.
Acute Rheumatism	1	..	3(2)	..	..	..	..	..	4
Amœbiasis	..	..	..	..	..	..	9	..	9
Ancylostomiasis	..	..	..	..	..	..	18	..	18
Anthrax	..	..	..	..	..	..	..	..	..
Bilharziasis	..	..	..	..	..	..	..	..	..
Brucellosis	..	..	..	..	..	..	..	..	..
Cholera	..	..	..	..	..	..	..	..	..
Chorea (St. Vitus)	..	..	..	..	..	..	..	..	..
Dengue	..	..	..	..	..	..	..	..	..
Diarrhœa (Infantile)	3(2)	20(14)	9(4)	..	1(1)	1	5	..	39
Diphtheria	..	..	..	..	..	..	..	..	..
Dysentery (Bacillary)	..	1	4(2)	..	1	..	..	..	6
Encephalitis	..	..	..	1	..	..	..	..	1
Filariasis	..	..	..	..	..	..	..	..	..
Homologous Serum Jaundice	..	..	..	..	..	..	..	..	..
Hydatid	..	..	..	..	..	..	..	..	..
Infective Hepatitis	75(31)	26(6)	12(1)	3(2)	2(2)	..	1	..	119
Lead Poisoning	..	..	..	..	..	..	..	..	..
Leprosy	..	..	..	..	..	..	..	..	..
Leptospirosis	..	..	6(2)	..	..	..	..	..	6
Malaria	..	..	2(2)	..	..	..	1	..	3
Meningococcal Infection	2(2)	..	..	..	..	..	..	..	2
Ophthalmia	..	..	..	..	..	..	..	..	..
Ornithosis	..	..	..	..	..	..	..	..	..
Paratyphoid	1(1)	..	..	..	..	..	..	..	1
Plague	..	..	..	..	..	..	..	..	..
Poliomyelitis	..	..	..	..	..	..	..	..	..
Puerperal Fever	2	..	1	..	..	..	..	..	3
Rubella	..	18(10)	..	2	15(13)	..	..	..	30
Salmonella Infection	..	..	..	..	1(1)	..	1	..	2
Scarlet Fever	6(1)	12(5)	3(2)	..	..	1	1	..	23
Smallpox	..	..	..	..	..	..	..	..	..
Tetanus	..	..	..	..	..	..	..	..	..
Trachoma	..	..	..	..	3(1)	..	11	..	14
Trichinosis	..	..	..	..	..	..	..	..	..
Tuberculosis	21(15)	17(16)	21(9)	3(2)	5(4)	1	..	..	68
Typhoid Fever	..	..	..	..	1	..	..	..	1
Typhus (Flea-, Mite- and Tick-borne)	..	..	..	..	..	..	..	..	..
Typhus (Louse-borne)	..	..	..	..	..	..	..	..	..
Yellow Fever	..	..	..	..	..	..	..	..	..

[1] Figures in parentheses are those for the metropolitan area.

April 6: 8.15 p.m., lecture at the Medical Society Hall, 426 Albert Street, East Melbourne, "The Anæmias of Pregnancy". The fee for this lecture is 15s., but those who are annual subscribers to the Committee are invited without further charge.

Dr. Orvar Swenson, Professor of Pædiatric Surgery at Tufts University School of Medicine, Boston, U.S.A., will be the first Felton Bequest Professor to come to Melbourne. He will be at the Royal Children's Hospital from March 31 to April 11. His programme is as follows:

April 3: 8 p.m., lecture at the Royal College of Surgeons, "Hydronephrosis and its Significance in Chronic Pyuria in Children". This lecture is open to all members of the medical profession.

April 8: At 8 p.m. Professor Swenson will speak at the meeting of the Pædiatric Society of Victoria at the Royal Children's Hospital on "The Diagnosis and Treatment of Hirschsprung's Disease with Particular Reference to Long-Term Results".

INFORMATION.

The address of the Melbourne Medical Post-Graduate Committee is 394 Albert Street, East Melbourne. Telephone: FB 2547.

Notes and News.

The Pharmaceutical Society of N.S.W.: Institutional and Industrial Pharmacists' Group.

A meeting of the Institutional and Industrial Pharmacists' Group (incorporated in the Pharmaceutical Society of N.S.W.) will be held on Wednesday, March 25, 1959, at 8 p.m., at the Pharmacy School, University of Sydney. The meeting will take the form of a symposium on "Promotion of Drugs—Cause and Effect". The chairman will be Mr. P. A. Smith, General Manager of Burroughs Wellcome & Co. (Aust.) Ltd., and the panel of speakers will be as follows: Mr. P. Fetherstone, Dr. P. Harvey, Mr. W. Howard, Mr. L. Lewis, Dr. St. Leger Moss. All members of the medical profession are invited to be present.

Nominations and Elections.

THE undermentioned have applied for election as members of the South Australian Branch of the British Medical Association:

Rice, Michael Scollin, M.B., B.S., 1958 (Univ. Adelaide), 117 Kensington Road, Norwood.

Beaumont, Gordon Dean, M.B., B.S., 1958 (Univ. Adelaide), 12 Hillsley Avenue, Everard Park.

Auricht, Clive Oswald, M.B., B.S., 1958 (Univ. Adelaide), 56 Elizabeth Street, Croydon.

Slavotinek, Anthony Hynek, M.B., B.S., 1958 (Univ. Sydney), c.o. Royal Adelaide Hospital, North Terrace, Adelaide.

The undermentioned have been elected as members of the South Australian Branch of the British Medical Association (qualifications are M.B., B.S., 1958 (Univ. Adelaide) unless otherwise stated): Hancock, Jonathon Yeatman; Goldsworthy, Rodney L.; Barlow, Douglas John; Hanson, Thomas A. S.; Casley-Smith, John R.; Huang, Anthony Y. T.; Clarnette, David L.; Murrell, Timothy G. C.; Vyse, Mignon R.; Humble, Dudley S.; Craig, Robert J.; Carter, Rodney F.; Wallace, Malcolm M.; Orchard, Barbara W.; Leonard, Ian F.; Hamilton, David W.; Morris, Neville J.; Hall, Donald R.; Cooper, Christopher J.; Forgan, Peter J.; Hamra, Lawrence K., M.B., B.S., 1957 (Univ. Adelaide); Moore, John L., M.B., B.S., 1956 (Univ. Adelaide).

Medical Appointments.

THE following appointments have been made to the honorary medical staff of the Royal Alexandra Hospital for Children, Camperdown, New South Wales:

Dr. J. Beveridge has been appointed Honorary Assistant Physician.

Dr. F. M. Stackpool has been appointed Honorary Assistant Radiologist.

Dr. J. B. Dowe has been appointed Honorary Ear, Nose and Throat Surgeon.

Dr. J. W. Hornbrook has been appointed Honorary Ophthalmic Surgeon.

Dr. P. M. V. Waddy has been appointed Honorary Assistant Ophthalmic Surgeon.

The following have been appointed Honorary Anæsthetists: Dr. J. U. Blacker, Dr. L. Harris, Dr. V. M. Hercus, Dr. A. D. Morgan, Dr. A. S. Paton, Dr. C. A. Sara.

Deaths.

THE following death has been announced:

MORGAN.—Arthur William Morgan, on March 5, 1959, at Templestowe, Victoria.

Diary for the Month.

MARCH 24.—New South Wales Branch, B.M.A.: Council (Election of Officers).
MARCH 25.—Victorian Branch, B.M.A.: Branch Council.
MARCH 26.—South Australian Branch, B.M.A.: Scientific Meeting.
MARCH 26.—Queensland Branch, B.M.A.: Council Meeting.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Medical Secretary, 135 Macquarie Street, Sydney): All contract practice appointments in New South Wales. Anti-Tuberculosis Association of New South Wales.

South Australian Branch (Honorary Secretary, 80 Brougham Place, North Adelaide): All contract practice appointments in South Australia.

Editorial Notices.

ALL articles submitted for publication in this Journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations, other than those normally used by the Journal, and not to underline either words or phrases.

References to articles and books should be carefully checked. In a reference the following information should be given: surname of author, initials of author, year, full title of article, name of journal, volume, number of first page of the article. The abbreviations used for the titles of journals are those of the list known as "World Medical Periodicals" (published by the World Medical Association). If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

Authors submitting illustrations are asked, if possible, to provide the originals (not photographic copies) of line drawings, graphs and diagrams, and prints from the original negatives of photomicrographs. Authors who are not accustomed to preparing drawings or photographic prints for reproduction are invited to seek the advice of the Editor.

Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary is stated.

All communications should be addressed to the Editor, THE MEDICAL JOURNAL OF AUSTRALIA, The Printing House, Seamer Street, Glebe, New South Wales. (Telephones: MW 2651-2-3.)

Members and subscribers are requested to notify the Manager, THE MEDICAL JOURNAL OF AUSTRALIA, Seamer Street, Glebe, New South Wales, without delay, of any irregularity in the delivery of this Journal. The management cannot accept any responsibility or recognize any claim arising out of non-receipt of journals unless such notification is received within one month.

SUBSCRIPTION RATES.—Medical students and others not receiving THE MEDICAL JOURNAL OF AUSTRALIA in virtue of membership of the Branches of the British Medical Association in Australia can become subscribers to the Journal by applying to the Manager or through the usual agents and booksellers. Subscriptions can commence at the beginning of any quarter and are renewable on December 31. The rate is £5 *per annum* within Australia and the British Commonwealth of Nations, and £6 10s. *per annum* within America and foreign countries, payable in advance.